101st Congress | HOUSE OF REPRESENTATIVES | Report
1st Session | | 101-107

VETERANS' HEALTH CARE PROGRAMS AMENDMENTS OF 1989

June 23, 1989.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. Montgomery, from the Committee on Veterans' Affairs, submitted the following

REPORT

[To accompany H.R. 901]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 901) to amend title 38, United States Code, to improve programs for the recruitment and retention of health-care personnel of the Department of Veterans Affairs, to extend certain expiring programs of that Department, and for other purposes, having considered the same, reports favorably thereon with an amendment, by unanimous voice vote, and recommends that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. SHORT TITLE; REFERENCES TO TITLE 38, UNITED STATES CODE; DEFINITION OF SECRETARY.

(a) Short Title.—This Act may be cited as the "Veterans' Health-Care Programs Amendments of 1989".

(b) References to Title 38.—Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

(c) Secretary Defined.—For purposes of this Act, the term "Secretary" means the Secretary of Veterans Affairs.

TITLE I—PERSONNEL PROVISIONS

SEC. 101. PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSE ASSISTANTS.

(a) In General.—Section 4107(e) is amended by adding at the end the following new paragraph:

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"(11) For purposes of this subsection, an employee of the Veterans Health Services and Research Administration who is a licensed practical or vocational nurse or a nurse assistant shall be treated in the same manner as a registered nurse.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the later of (1) October 1, 1989, or (2) the date of the enactment of this Act.

SEC. 102. REVISION OF CERTAIN LIMITATIONS ON OUTSIDE EMPLOYMENT FOR CERTAIN EMPLOYEES.

Section 4108 is amended by adding at the end the following new subsection:

"(e) Any provision of this title limiting employment outside of the Department by an employee of the Department shall not apply to an employee described in section 4104(3) of this title.".

SEC. 103. REVISION IN LIMITATION ON COMPENSATION OF HEALTH-CARE PERSONNEL WHO ARE RETIRED MILITARY PERSONNEL.

(a) EXTENSION TO ALL HEALTH-CARE PERSONNEL.—Section 4107(i) is amended—

(1) by inserting ", and registered nurse positions," after "physician positions"; and

(2) by adding at the end the following new sentence: "The authority of the Secretary under the preceding sentence with respect to registered-nurse positions expires on September 30, 1992.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(1) shall take effect on the first day of the first pay period beginning on or after the later of (1) October 1, 1989, or (2) the date of the enactment of this Act.

SEC. 104. REVISION IN LIMITATION ON PAY OF CERTAIN PHYSICIAN POSITIONS.

(a) ENHANCED PAY FLEXIBILITY FOR EXTREMELY-DIFFICULT-TO-FILL PHYSICIAN POSITIONS.—Section 4107 is amended by adding at the end the following new subsection:

"(k) In the case of specific physician positions in a specialty which the Secretary has determined to be a specialty in which it is extremely difficult to recruit and retain physicians, the Secretary may waive the applicability to any such position of—

"(1) the limitations in subsection (d)(3) of this section and section 5308 of title 5; and

"(2) paragraphs (2) and (3) of subsection (g) of this section.".

(b) EFFECTIVE DATE.—Subsection (k) of section 4107 of title 38, United States Code, shall take effect on the first day of the first pay period beginning on or after the later of (1) October 1, 1989, or (2) the date of the enactment of this Act.

SEC. 105. APPOINTMENT OF CERTAIN INDIVIDUALS IN HEALTH-CARE POSITIONS.

Section 4106 is amended by adding at the end the following new subsection:

"(h)(1) The Secretary may appoint qualified individuals in the competitive civil service without regard to the provisions of subchapter I of chapter 33 of title 5 (other than sections 3303 and 3328 of such title).

"(2) For purposes of this subsection, an individual shall be considered to be a qualified individual if the individual—

"(A) has a recognized degree or certificate from an accredited institution in a health-care profession or occupation; and

"(B) is appointed to and has successfully completed a clinical education program affiliated with the Department.

"(3) In using the authority provided by this subsection, the Secretary shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5.".

SEC. 106. LEAVE-SHARING PROGRAM.

(a) AUTHORITY FOR PROGRAM.—Section 4108 is amended by adding after subsection (e) (as added by section 102) the following new subsection:

"(f)(1) The Secretary may carry out a leave-sharing program for employees subject to this section who face medical emergencies (either for themselves or family members). Any such program shall be consistent with the leave-sharing programs authorized in subchapter III (beginning with section 6331) and subchapter IV (beginning with section 6361) of chapter 63 of title 5 for employees appointed under title 5.

"(2) The authority to carry out such a program shall terminate on September 30, 1994.".

(b) EFFECTIVE DATE.—Subsection (f) of section 4108 of title 38, United States Code, as added by subsection (a), shall take effect on October 1, 1989.

TITLE II—HEALTH PROGRAM AMENDMENTS

SEC. 201. EXTENSION OF EXPIRING PROGRAMS.

(a) Respite Care.—Section 620B(e) is repealed.

(b) State Home Grant Authority.—Section 5033(a) is amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1992."

(c) Homeless Veterans.—Section 115(d) of the Veterans' Benefits and Services Act of 1988 (Public Law 100-322; 102 Stat. 501) is amended by striking out "September 30, 1989" and inserting in lieu thereof "September 30, 1992".

(d) Annual Report on Means Test for Furnishing Non-Service-Connected Health Care.—Section 19011(e)(1) of the Veterans' Health Care Amendments of 1986 (title XIX of Public Law 99-272, 100 Stat. 379) is amended by striking out "and 1988" and inserting in lieu there of ", 1988, 1989, 1990, and 1991".

(e) Annual Report on PTSD.—Section 110(e)(2) of the Veterans' Health Care Act of 1984 (Public Law 98-528; 98 Stat. 2693) is amended by striking out "three" and inserting in lieu thereof "six".

SEC. 202. HOUSING PROGRAM.

Section 9 of the Veterans' Home Loan Program Improvements and Property Rehabilitation Act of 1987 (38 U.S.C. 1820 note; 101 Stat. 1320) is amended—

(1) in subsection (a)(3)(B)(i), by striking out "solely as a shelter" and inserting in lieu thereof "as a shelter or as transitional housing";

(2) by redesignated subsections (c) and (d) as subsection (d) and (e), respectively;

(3) by inserting after subsection (b) the following new subsection:

"(c) Veterans Participating in Compensated Work Therapy Program.—(1) To assist veterans who are participants in a compensated work therapy program authorized under section 618 of title 38, United States Code, the Secretary of Veterans Affairs may convey to persons described in pargraph (2) real property and improvments described in subsection (a)(2) for an amount not less than 75 percent of the fair market value of such real property and improvements.

"(2) The Secretary may convey such property to persons who enter into an aggreement with the Secretary to employ veterans who into an agreement with the Secretary to employ veterans who are participations in a compensated work therapy program authorized under such section 618.

"(3) The Secretary may include appropriate enforcement provisions in any agreement described in paragraph (2), including provision for reasonable liquidated damages."; and

(4) in subsection (d), as redesignated by paragraph (2), by striking out "subsections (a) and (b)" and inserting in lieu thereof "this section".

SEC. 203. COMPENSATED WORK THERAPY PROGRAM.

(a) Authorized Sources for Provision of Therapeutic Work.—(1) Subsection (b)(1) of section 618 is amended by striking out "contractual arrangement with private industry or other sources outside the Veterans' Administration" and inserting in lieu thereof "a contract or other arrangement with any appropriate source (whether or not an element of the Department of Veterans Affairs or of any other Federal entity)"

(2) Subsection (c)(1) of such section is amended by striking out "carrying out the provisions of" and inserting in lieu thereof "furnishing rehabilitative services authorized in".

(b) Authority To Establish and Operate Therapeutic and Rehabilitative Activities Transitional Housing.—(1) The Secretary may carry out a demonstration program of transitional housing in accordance with this subsection. Under that program, the Secretary may purchase, lease, or otherwise acquire residential housing and may operate each residence acquired under this subsection as transitional housing for veterans described in paragraph (2).

(2) The veterans for whom transitional housing may be provided under this subsection are veterans—

(A) who are furnishing services to the Department of Veterans Affairs under subsection (a) of section 618 of title 38, United States Code; or

(B) who are furnished therapeutic work pursuant to subsection (b) of that section.

(3) The Secretary may use such procurement procedures for the purchase, lease, or other acquisition of residential housing for purposes of this subsection as the Secretary considers appropriate to expedite the opening and operation of transitional housing and to protect the interests of the United States.

(4) A residence may be operated as transitional housing for veterans described in paragraph (2) under the following conditions:

(A) Only veterans described in such paragraph and a house manager may reside in such residence.

(B) Each resident, other than the house manager, shall pay rent for the period of residence in such housing.

(C) In the establishment and operation of housing under this subsection, the Secretary shall consult with appropriate representatives of the community in which the housing is established and shall comply with zoning requirements, building permit requirements, and other similar requirements applicable to other real property used for similar purposes in the community.

(D) The residence shall meet State and community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located, but fire and safety requirements applicable to buildings of the Federal Government shall not apply to such property.

(5) The Secretary shall prescribe the qualifications for house managers for transitional housing operated under this subsection. The Secretary may provide for free room and subsistence for house managers in addition to or instead of payment of a fee for such services.

(6) The Secretary may operate as transitional housing under this subsection—

(A) any suitable residential property acquired by the Secretary as the result of a default on a loan made, guaranteed, or insured under chapter 37 of title 38, United States Code; and

(B) any other suitable residential property purchased, leased, or otherwise acquired by the Secretary.

(7)(A) In the case of the purchase of any property referred to in paragraph (6)(A), the Secretary shall transfer from the Special Therapeutic and Rehabilitation Activities Fund to the Loan Guaranty Revolving Fund the amount equal to the amount that the Secretary would charge for the sale of such property to a nonprofit organization or a State for use as a shelter for homeless veterans.

(B) In the case of any residential property purchased by the Secretary of Veterans Affairs from the Department of Housing and Urban Development under this section, the amount charged by the Secretary of Housing and Urban Development for that property may not exceed the amount that the Secretary of Housing and Urban Development would charge for the sale of such property to a nonprofit organization or a State for use as a shelter for homeless persons.

(8) Subject to the authority, direction, and control of the Secretary, the Chief Medical Director shall be responsible for the management, maintenance, and disposition of property acquired for the purpose of this subsection.

(9) The Secretary shall prescribe—

(A) a procedure for establishing reasonable rental rates for persons residing in transitional housing; and

(B) appropriate limits on the period for which such persons may reside in transitional housing.

(10) The Secretary may dispose of any property acquired for the purpose of this subsection. The proceeds of any such disposal shall be credited to the Special Therapeutic and Rehabilitation Activities Fund.

(c) AVAILABILITY OF THE SPECIAL THERAPEUTIC AND REHABILITATION ACTIVITIES FUND FOR COMPENSATED WORK THERAPY COMMUNITIES.—Section 618(c) is amended—

(1) in paragraph (1), by inserting "and for the purpose of carrying out section 203 of the Veterans' Health-Care Programs Amendments of 1989" before the period at the end of the first sentence; and

(2) in paragraph (2)—

(A) by inserting "and all funds received by the Department as rent under section 203 of the Veterans' Health-Care Programs Amendments of 1989" in the first sentence after "paragraph (2) of such subsection,"; and

(B) by adding at the end the following new sentence: "The Secretary may also distribute out of the fund such amounts as may be necessary for the acquisition, management, maintenance, and disposition of real property for the purpose of carrying out such section 203.".

(d) REPORT.—After the program under this subsection has been in effect for three years, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the operation of the program. The Secretary shall include in the report such recommendations for continuation or expansion of the program as the Secretary considers appropriate.

SEC. 204. ELIGIBILITY FOR OUTPATIENT MEDICAL SERVICES.

(a) CONFORMITY WITH ELIGIBILITY FOR INPATIENT CARE.—Section 612(a) is amended—

(1) in paragraph (1), by striking out "determines are needed—" and all that follows in that paragraph and inserting in lieu thereof "determines are needed to any veteran who is eligible for hospital care under section 610(a)(1) of this title, subject to the same limitations as apply under subparagraphs (A) through (I) of that section with respect to eligibility for hospital care under that section.";

(2) by striking out paragraphs (2) and (3);

(3) by redesignating paragraph (4) as paragraph (2) and in that paragraph striking out "paragraph (5)" and inserting in lieu thereof "paragraph (3)";

(4) by redesignating paragraph (5) as paragraph (3) and in that paragraph striking out "paragraph (4)" and inserting in lieu thereof "paragraph (2)"; and

(5) by redesignating paragraph (6) as paragraph (4).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on October 1, 1989.

TITLE III—HEALTH-CARE MANAGEMENT

SEC. 301. PROGRAM FOR IMPROVED SYSTEM FOR COLLECTION OF FEES.

(a) PROGRAM.—(1) The Secretary shall carry out a program for the establishment of an improved system for the administration and collection of fees and other amounts payable to the United States under Department of Veterans Affairs receipts programs.

(2) For purposes of this section, the term "Department of Veterans Affairs receipts programs" means provisions of law administered by the Veterans Health Services and Research Administration under the title 38, United States Code, for the collection of fees and other amounts payable to the United States,—including the provisions relating to—

(A) fees charged to third parties;

(B) amounts recoverable by the United States under section 629 of title 38, United States Code; and

(C) amounts payable as first-party medical copayments authorized in such title.

(b) AUTOMATED PROGRAM FOR BILLING AND COLLECTION.—(1) As part of the system established under subsection (a), the Secretary shall provide for the development of an automated program to carry out billing and collection of fees and other amounts. The automated program shall have the capability to process each Department of Veterans Affairs receipts program listed in subparagraphs (A) through (C) of subsection (a)(2).

(2) In developing the billing and collection program required by paragraph (1), the Secretary shall use services of the private sector to the maximum extent feasible.

(3) Not later than January 31, 1992, the Secretary shall submit to the Committees on Veterans Affairs of the Senate and House of Representatives a report on the operation of this subsection during fiscal years 1990 and 1991. The report shall be based on a study, to be done in consultation with the Comptroller General of the United States, comparing the experience in carrying out this subsection through the use of employees of the Department at not more than 20 medical centers with the experience in carrying out this subsection through the use of contractor services at not more than 20 medical centers.

(c) ALLOCATION OF AMOUNTS COLLECTED.—(1) The Secretary shall defray costs of administering the automated program, including the costs of any contract under the program, from amounts received by the Secretary through the program.

(2) Of amounts collected or recovered by the Secretary for any fiscal year under the Department of Veterans Affairs receipts programs listed in subparagraphs (A) through (C) of subsection (a)(2) that remain after costs are defrayed pursuant to paragraph (1), the Secretary shall cover into the general fund of the Treasury as miscellanous receipts an amount equal to the amount which was estimated by the Congressional Budget Office in February 1989 to be the total amount which would be recovered or collected for fiscal year 1990 under those receipts programs (assuming this section had not been enacted).

(3) Of amounts collected or recovered by the Secretary for any fiscal year under the Department of Veterans Affairs receipts programs listed in subparagraphs (A) through (C) of subsection (a)(2) that remain after costs are defrayed pursuant to paragraph (1) and the requirement of paragraph (2) has been met, the Secretary shall allocate remaining amounts as follows:

(A) 50 percent shall be credited to the Medical Care Account of the Department of Veterans Affairs.

(B) 50 percent shall be credited to the Nursing Home Revolving Fund of the Department.

(4) The Secretary shall prescribe regulations for the allocation to the medical centers of the Department of amounts credited to the Medical Care Account of the Department under paragraph (3). Those regulations shall be designed to provide incentives to directors of medical centers to increase the recovery and collection of amounts owed to the United States under programs listed in subsection (a)(2) that are attributable to health care and services furnished at their medical centers and, in the case of medical centers at which such recovery and collection has been at above average levels, to maintain and increase such levels.

(d) NURSING HOME REVOLVING FUND.—Section 5016 is amended—

(1) by striking out "realized from a transfer pursuant to" in subsection (a)(1) and inserting in lieu thereof "referred to in section 629(g)(3) and"; and

(2) by striking out "may be made only as" in subsection (b)(1) and inserting in lieu thereof "shall be made subject to such limitations as are".

(e) EFFECTIVE DATE.—This section shall apply with respect to funds collected or recovered after September 30, 1989.

SEC. 302. ELIGIBILITY OF MILITARY DEPENDENTS FOR HEALTH CARE UNDER SHARING AGREEMENTS.

Section 5011(g)(5) is amended by inserting after "title 10" the following: "or a dependent (as defined in section 1072(2) of such title) who is eligible for care under section 1076 of such title".

SEC. 303. CHAMPVA PROGRAM.

(a) LIST OF BENEFICIARIES.—The Secretary shall compile an accurate and complete list of individuals eligible as of October 1, 1989, for benefits under section 613 of title 38, United States Code. Such list shall be compiled not later than October 1, 1989, and shall be maintained and periodically updated thereafter. The Secretary may pay benefits under that section only to persons whose names are included on the list.

(b) PROGRAM REVIEW.—Not later than October 1, 1989, the Secretary shall establish a procedure for the periodic review of the need for, the cost effectiveness of, and the appropriateness of the provision of health care by the Secretary under section 613 of such title.

(c) INSPECTOR GENERAL REVIEW.—Not later than December 1, 1989, the Inspector General of the Department of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the compliance of the Secretary with subsections (a) and (b). If the report indicates that the Secretary is not in compliance with either such subsection, the Secretary shall promptly submit to those committees a report explaining the reason for any such noncompliance and the plans of the Secretary to correct the deficiency.

(d) STUDY OF ALTERNATIVES.—The Secretary shall carry out a study of alternative methods for providing for the costs of health care which are currently provided under section 613 of such title. In carrying out the study, the Secretary shall consider methods which would result in a substantially unchanged cost to the United States while providing improved health benefits at lower costs to beneficiaries.

(2) The Secretary shall submit a report on the results of the study to Congress not later than one year after the date of the enactment of this Act.

(3) There is authorized to be appropriated the sum of $500,000 to carry out the study under this subsection.

SEC. 304. CANTEEN SERVICE.

(a) LIMITATION ON EMPLOYMENT.—Section 4203 is amended by adding at the end the following new subsection:

"(c) A contract or other agreement may not be made by or on behalf of the Service for performance by an individual not directly employed by the United States of any activity otherwise performed by an individual employed by the United States who is compensated with nonappropriated funds.".

(b) INDEPENDENT STATUS WITHIN THE DEPARTMENT OF VETERANS AFFAIRS.—Section 4208 is amended—

(1) by striking out "It is the purpose of this chapter that, under" and inserting in lieu thereof "Under the"; and

(2) by adding at the end the following: "The need of the Service may not be required to report to or be supervised by any official of the Department other than the Secretary and Deputy Secretary.".

SEC. 305. COMMUNITY NURSING HOMES.

(a) Rescission of Regulation.—The amendment to Veterans' Administration medical regulations relating to the use of community nursing home care facilities that was effective as of May 23, 1988, and which is further described in subsection (b) is hereby rescinded, and the provisions of regulations replaced by such regulations described in subsection (b) are hereby restored.

(b) Regulation Described.—Subsection (a) applies to the amendment to title 38 of the Code of Federal Regulations section 17.51a published in the Federal Register on April 21, 1988 (53 Fed. Reg. 13120).

SEC. 306. PROVISION OF PROSTHETIC APPLIANCES.

Section 5023 is amended—

(1) by inserting "(a)" before "The Administrator"; and

(2) by adding at the end the following:

"(b) The Secretary shall develop standards, based on the number of eligible veterans seeking prosthetic and sensory aids services from the Department at a medical facility, for the staffing of medical facilities of the Department to provide for—

"(1) the assignment of sufficient numbers of qualified disabled prosthetic representatives at each medical center; and

"(2) the operation of prosthetic and sensory aids services at each medical facility with an active prosthetic patient load.

"(c) The Secretary shall carry out a program for the training and continuing education of prosthetic representatives, orthotists, prosthetists, and other health care professionals involved in providing and prescribing prosthetic services.

"(d) Not later than February 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the funding and operation of the prosthetics program of the Department. Each such report shall include the following:

"(1) A description and analysis, by medical center, of the duration of time between the date on which each order for prosthetic services was placed by an eligible veterans during the period of time covered by the report and the date on which such service was delivered. Such analysis shall include a statement of the following:

"(A) A list of facilities at which the duration of time exceeded 5 days in any case.

"(B) The number of orders, shown by facility, for which the duration of time was more than five days and the actual amount of time elapsed in filling each such order.

"(C) The total dollar amount of orders for which the duration of time was more than five days.

"(D) The reasons for the duration of time for delivering services in accordance with such orders being in excess of five days.

"(2) A statement of the number of medical facilities at which qualified disabled prosthetic representatives are employed and the number of medical centers operating Prosthetic and Sensory Aids Services.

"(3) A description of the training provided to prosthetic representatives, orthotists, prosthetists, and other health care professionals involved in providing and prescribing prosthetic services.

"(4) A description of the actions taken during the period covered by the report to expedite the purchases of prosthetic appliances.".

Introduction

On April 12, 1989, the Subcommittee on Hospitals and Health Care held a hearing to receive testimony on H.R. 901, legislation to enhance recruitment and retention of nurses as well as to improve certain Department of Veterans Affairs (DVA) programs. Testimony was received from the Honorable Harley O. Staggers; the Department of Veterans Affairs; the Blinded Veterans' Association; the Veterans of Foreign Wars; the Paralyzed Veterans of America; the Disabled American Veterans; The American Legion; the American Nurses Association; and, the Nurses Organization of the VA.

Testimony was received by the Subcommittee on April 26, 1989 on H.R. 1780, introduced by the Honorable Jim Jontz, a bill to align DVA outpatient care eligibility criteria with that for hospital, or inpatient, care. Witnesses at that hearing were the Honorable Tom Lewis; the Department of Veterans Affairs; the American Psychiatric Association; the Disabled American Veterans; the Veterans of Foreign Wars; the Paralyzed Veterans of America; The American Legion; and, the American Ex-Prisoners of War, Inc.

Field hearings were held at Northport, New York and West Haven, Connecticut on May 15, 1989 on the effect of budget constraints upon the delivery of health care as well as recruitment and retention problems. Testimony was received at Northport from the Department of Veterans Affairs; the Executive Associate Dean of the School of Medicine at the State University of New York at Stony Brook which is affiliated with the Northport DVA Medical Center, and public witnesses. Testimony on the same subject was also received at West Haven from the DVA; the Associate Dean for Government and Community Affairs at the Yale University School of Medicine; the Commissioner of the Connecticut Department of Veterans Affairs; the Commandant of the Connecticut Veterans Home & Hospital; the Veterans of Foreign Wars; the Vietnam Veterans of America; the Eastern Paralyzed Veterans Association; the Blinded American Veterans Foundation; the American Ex-Prisoners of War, the Concerned Veterans of Connecticut; the Jewish War Veterans; the Polish American Veterans; The American Legion; the Disabled American Veterans; and the AMVETS.

On June 7, 1989, the subcommittee met and unanimously recommended to the full committee H.R. 901, as amended with an amendment in the nature of a substitute, and H.R. 1780.

On June 20, the full committee met and unanimously recommended that H.R. 901, as amended, with an amendment in the nature of a substitute, be reported to the House.

Summary of Reported Bill

H.R. 901, as reported, would:

(1) Provide, on or after October 1, 1989, that licensed practical or vocational nurses and nursing assistants are eligible for premium pay for Saturday duty on the same basis as registered nurses.

(2) Clarify the limitation on outside employment for Department of Veterans Affairs health-care personnel employed under the auspices of title 5, United States Code, and paid under the auspices of title 38, United States Code.

(3) Provide that no reductions shall be made from the salaries of Department of Veterans Affairs nurses who provide direct patient care and who are eligible for military retirement pay effective on the first day of the first pay period beginning on or after the date of enactment.

(4) Permit the Secretary of Veterans Affairs, on a case-by-case basis for difficult-to-recruit physician specialties, to exceed the maximum salary limitations for such physicians.

(5) Permit health-care personnel hired under the auspices of title 5, United States Code, to be hired by the Department of Veterans Affairs if they have a recognized degree or certificate from an accredited academic institution and have successfully completed a

clinical education program affiliated with the Department of Veterans Affairs.

(6) Authorize establishment of a 5-year leave sharing pilot program for health-care employees of the Department of Veterans Affairs which would permit the voluntary transfer of annual leave similar to the program currently authorized for title 5, United States Code, employees.

(7) Make permanent the Department of Veterans Affairs program for providing respite care to eligible veterans.

(8) Extend for three years the authority to make grants for the State Veterans' Home Program from September 30, 1989 until September 30, 1992.

(9) Extend for 3 years, or until September 30, 1992, the pilot program of contract community-based residential care—for homeless chronically mentally ill veterans, veterans being furnished hospital or nursing home care by the Administrator for a chronic mental illness disability and veterans with service-connected chronic mental illness—in halfway houses, therapeutic communities, psychiatric residential treatment centers and other community-based treatment facilities.

(10) Extend the annual reporting requirement for the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder for 3 years, or until September 30, 1992.

(11) Extend the requirement that the Secretary submit a report to the Committees on Veterans Affairs of the House and Senate describing the number of veterans receiving DVA health care and the type, if any, of health insurance they possess; the number of veterans who applied for DVA health care and did not receive it; and, the reasons why veterans were denied health care until September 30, 1992.

(12) Authorize discounts on the sale of DVA difficult-to-sell foreclosed properties to non-profit organizations for use as transitional housing for homeless veterans in addition to use as shelters as is provided in current law.

(13) Allow the Secretary, in order to provide for therapeutic work for veterans under the DVA's rehabilitative Compensated Work Therapy Program, to contract with Federal agencies rather than being limited to contracting only with private and non-profit entities as is required in current law.

(14) Authorize a transitional housing demonstration program to combine the Compensated Work Therapy Program with a therapeutic residential living program to aid the discharge of psychiatric patients into the community.

(15) Require a pilot program for an improved, automated management system for billing and collections of fees charged to third parties and for first-party medical copayments. Require that the Secretary report to the Committees on Veterans' Affairs of the Senate and House of Representatives, not later than January 31, 1992, on the operation of the program during fiscal years 1990 and 1991. The report is to be based upon a study, accomplished in consultation with the Comptroller General of the United States, comparing the experience of the program using DVA employees at not more than 20 medical centers versus using contractual services at

not more than 20 medical centers. Provide that the amounts received under the program shall be allocated as follows:

(a) costs of collections to be defrayed from funds received;

(b) a sum to the Treasury of the United States equal to the amount estimated by the Congressional Budget Office to be the total which would have been collected during fiscal year 1990 without enactment of this provision;

(c) 50 percent of remaining amount to the Medical Care Account for distribution to medical centers; and

(d) 50 percent of remaining amount to the Nursing Home Revolving Fund.

(16) Authorize dependents of DOD beneficiaries to receive health care on a space available, referral basis, in Department of Veterans Affairs medical facilities which have DVA/DOD sharing agreements.

(17) Direct the Secretary to compile an accurate and complete list of individuals eligible as of October 1, 1989 for benefits under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) by October 1, 1989. Require that the Department of Veterans Affairs Inspector General submit a report to the Committees on Veterans' Affairs of the House and Senate by December 1, 1989 on the Secretary's compliance in compiling the list of eligible beneficiaries.

(18) Remove the Veterans Canteen Service from the direction and supervision of the Chief Medical Director and prohibit mandatory contracting out of services performed by an individual who is compensated by non-appropriated funds under provisions of OMB Circular A-76.

(19) Rescind the DVA medical regulation, which became effective on May 23, 1988, limiting the length of an extension of a contract for care of a veteran with non-service-connected disabilities in a community nursing home.

(20) Require the Secretary to develop staffing standards for the provision of prosthetic appliances at medical facilities as well as a program for training and continuing education of health care professionals involved in providing and prescribing prosthetic services. Provide that the Secretary shall report to the Committees on Veterans Affairs of the House and Senate on the funding and operation of the prosthetics program no later than February 1 of each year.

(21) Require the Secretary of Veterans Affairs to furnish needed outpatient medical services in conformity with eligibility for DVA hospital care to the following veterans:

CATEGORY A

a. Veterans with service-connected disabilities;

b. Former prisoners of war;

c. Veterans exposed to certain herbicides and ionizing radiation;

d. Veterans disabled as a result of DVA treatment or vocational rehabilitation;

e. Veterans of the Mexican border period or World War I; and

f. Non-service-connected veterans with one dependent whose income does not exceed $19,759 (or $16,466 for a single veteran). The income level is increased by $1,098 for each additional dependent.

CATEGORY B

Permit the Secretary to furnish needed outpatient medical services reasonably necessary in preparation for hospital admission or to obviate the need for hospital admission to non-service-connected disabled veterans whose income is between $16,467 and $21,954 for a single veteran and between $19,760 and $27,433 for a veteran with one dependent (plus $1,098 for each additional dependent) to the extent that resources and facilities are available.

CATEGORY C

Permit the Secretary to furnish needed outpatient medical services reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission to any non-service-connected disabled veteran whose income is at least $21,955 if single or $27,444 if married (plus $1,098 for each additional dependent) to the extent that resources and facilities are available and provided the veteran agrees to pay a nominal fee.

Background and Discussion

PREMIUM PAY FOR LICENSED PRACTICAL OR VOCATIONAL NURSES AND NURSE ASSISTANTS

During the hearings on the recruitment and retention of nurses referred to above, attention was also focused on the serious problems of recruiting and retaining licensed practical and vocational nurses and nurse assistants for DVA employment. The services of persons in these occupations are becoming more critical due to the shortage of registered nurses. In the committee's nationwide survey, over 1,200 licensed practical nurses and licensed vocational nurses (LPN/LVN) vacancies were reported to exist on June 30, 1988. The medical center director respondents also reported that, even if all the vacancies were filled, approximately 1,500 additional LPN/LVNs would be necessary to bring the DVA up to comparable community staffing levels. A significant reason for the Department's difficulty in the recruitment and retention of LPN/LVN and nurse assistants is reported as pay or pay-related.

The DVA's "Report of the 1987 Survey of Health Occupational Staff" (DVA Office of Personnel and Labor Relations, April 29, 1988) showed that vacancy rates increased during fiscal year 1987 for licensed practical/vocational nurses from 8.6 percent to 10.6 percent and the turnover in fiscal year 1987 was 30.2 percent, up from 18.9 percent in the previous year. In addition, the losses due to higher pay for the same level of responsibility in the private sector accounted for the largest percentage of losses, from 14 percent in fiscal year 1986 to 20 percent in fiscal year 1987. The lack of Saturday premium pay was reported to be a disadvantage to DVA employment by 24.7 percent of the medical centers.

Section 101 of the reported bill, as amended, would amend section 4107(e) to include licensed practical/vocational nurses and nurse assistants for purposes of Saturday/Sunday premium pay. Currently, LPN/LVNs receive such pay on a discretionary basis, but under this amendment they would be treated in the same manner as an RN. During the 100th Congress, the committee recommended this change as part of H.R. 5114, but the Senate failed to act on this measure. However, the committee considers the continuing critical nature of nurse staffing in the DVA to justify another attempt to rectify the problem.

CLARIFICATION OF CERTAIN LIMITATIONS WITH RESPECT TO OUTSIDE EMPLOYMENT

The authority for the DVA to set rates of pay and qualifications standards for certain title 5, United States Code, employees, i.e. physical therapists, respiratory therapists and licensed practical/vocational nurses, was contained in P.L. 98-160 and for pharmacists and occupational therapists in P.L. 100-322. The Congress emphasized, in the report language accompanying the legislation which created these "hybrid" occupational groups, that it was its intent not to diminish or impair in any way the rights and protections guaranteed the employees under the express provisions of title 5, U.S.C. Instead, the intent was simply to provide the pay and appointment flexibility that was necessary to ensure that the DVA might continue to compete for these hard-to-recruit personnel.

In order to clarify the intent with specific regard to employment outside the DVA, often referred to as "moonlighting", and in the interest of improving the ability of the DVA to compete for these hard to recruit employees, section 102 of the reported bill would explicitly authorize "moonlighting" for so-called hybrid occupations.

PROTECTION OF MILITARY RETIREMENT PAY FOR NURSES

Current law, section 4107(i) of title 38, U.S.C., authorizes the DVA to make exceptions to the restrictions on the simultaneous receipt of Federal retirement pay and a Federal salary in situations of a "severe shortage of well-qualified candidates in physician positions which otherwise cannot readily be met." In testimony before the committee and in the survey of DVA medical facilities conducted by the committee, considerable evidence was obtained regarding the severe shortage of well-qualified registered nurses.

Therefore, section 103 of the reported bill would enable retired military nurses who provide direct patient care to accept DVA employment without losing their earned retirement benefits.

Testimony at the April 12, 1989 hearing raised questions regarding the potential for this authority to result in recruitment of additional nurses. Therefore, in order to ensure a review of the effectiveness of this authority, the bill would provide for the authority to expire on September 30, 1992.

PHYSICIAN SALARY CAP WAIVER

During hearings before the committee and in the committee's nationwide survey, the particular difficulty in recruiting certain physician specialties was documented. These especially hard-to-recruit specialties currently include anesthesiology, radiology, and psychiatry, among others. The main reason given in testimony for the recruitment difficulty was low Federal pay which in many instances requires the medical center directors to contract for such specialty services at high costs. Such contracts totaled $19.6 million in fiscal year 1988 for a total of 165.9 full-time equivalent employees.

Therefore, section 104 of the reported bill would authorize the Secretary to waive the applicable pay restrictions for physicians in extremely difficult to recruit and retain specialties. The intent of the committee is not to apply this waiver authority to all physicians in the designated scarce medical specialities. Instead, the committee expects that the authority would be used to employ physicians in lieu of contracting for such services.

APPOINTMENT OF CERTAIN INDIVIDUALS IN HEALTH CARE POSITIONS

As documented in hearings before the committee, in a report of site visits, and in the committee's nationwide survey of medical centers, the DVA is experiencing staff shortages in certain "allied health care" professions where the appointment to DVA employment is governed by title 5, U.S.C. Testimony before the committee indicated that highly motivated allied health-care employees who might consider employment with the DVA become frustrated with the length and complexity of title 5 civil service procedures and accept employment offers elsewhere.

Under its statutory mission to develop and to carry out a program of education and training of health-care personnel for the nation, the DVA annually trains, in clinical education programs in DVA facilities, approximately 50,000 students in these allied professions which include: pharmacology, occupational therapy, psychology, social work, audiology, speech pathology, dietetics, and recreational therapy. Fewer than six percent of these students take jobs with the DVA.

Section 105 of the reported bill would allow the DVA to directly appoint highly qualified graduates in these allied health-care professions, who have a recognized degree or certificate from an accredited institution in a health-care profession or occupation, and who are appointed to and successfully complete a clinical education program affiliated with the DVA. The reported bill would allow well-trained individuals who know the DVA system and who are known by its clinical leadership, to be directly appointed without requiring compliance with certain civil service procedures.

The committee intends that this provision would aid the DVA in its recruitment and retention efforts and would enable the DVA to gain directly from the clinical education and training programs in which the DVA is engaged across the country. The committee further intends that the individuals who are so directly appointed be graduates who meet the DVA's high standards for such positions as evidenced by their academic credentials and by the successful completion of an affiliated DVA clinical education program.

LEAVE SHARING

Leave sharing involves the voluntary transfer of annual leave from one employee to another in order to help employees cope with emergency leave situations, such as when an employee is faced with an extended illness and has only a limited amount of personal leave time available. A temporary leave sharing program was implemented in the Department of Veterans Affairs covering employees appointed under both title 5 and title 38. This program worked so well that a 5-year program was authorized for title 5 employees in Public Law 100-566. However, title 38 employees are covered only by the temporary program which terminates on September 30, 1989. The result is inequitable treatment of employees under the two appointment authorities.

Therefore, section 106 would amend section 4108, title 38, U.S.C., to authorize the establishment of a 5-year leave sharing program for DVA health care employees appointed under title 38. This program would permit the voluntary transfer of annual leave much like the program currently in place for title 5 employees. Section 106 also would authorize existing leave balances in the temporary program to be "carried forward" into the 5-year program, as is the case with the title 5 program. The termination date for this authority of September 30, 1994, also consistent with the title 5 program, would ensure a more thorough assessment of the costs and benefits of this program.

EXTENSION OF EXPIRING PROGRAMS

Respite care.—The ultimate goal of respite care is to help individuals with serious chronic illnesses remain in their homes as long as possible before having to resort to institutional care. It is widely agreed that, where medically feasible, maintaining a person at home is better for the person's overall health status than institutional care, and is a far more efficient and cost-effective way to meet individuals' health-care needs. Very often a key to the patient being able to remain at home is the regular availability of a spouse, child, or other relative or close friend of the patient to provide meals, homemaker, and other personal care services that, combined with outpatient treatment, home health services, or other sources of medical attention, meet the patient's full range of needs. Respite care, by providing scheduled relief for the primary provider or providers of personal care, makes it possible to maintain the person in need of care at home for a longer period of time or indefinitely.

Section 201(a) of the reported bill would amend title 38, section 620(B) to provide ongoing authority for the DVA's respite care program, which now expires on September 30, 1989. Respite care services allow the DVA to provide chronically ill veterans who reside at home with brief, planned periods of care in DVA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. Testimony provided to the committee indicates that the program appears to be working very well as an effective mechanism for avoiding institutional care. There is no significant cost associated with the program and the DVA fully supports the extension of this successful program.

State Veterans Home Program.—The State Veterans' Home Program has two parts. The Department of Veterans Affairs State

Home Grant program provides grant support to assist States in the construction or acquisition of State Home facilities and also in the remodeling of existing facilities. The DVA may provide up to 65 percent of the cost of constructing or acquiring domiciliary or nursing home care facilities and up to 65 percent of the cost of remodeling existing buildings for the provision of domiciliary, nursing home or hospital care in State homes. In addition, the State Veterans' Home Program authorizes per diem payment for care of eligible veterans in State Veterans' Homes.

The State Veterans Home Program has grown from eleven homes in eleven States in 1888 to a present number of 58 DVA recognized homes in 36 States. These Homes currently have over 18,000 DVA approved beds and in fiscal year 1988 provided more than 4.8 million days of care. These facilities make it possible to provide medical care to many more veterans than can receive care in DVA facilities, while at the same time, doing so in a cost-effective manner.

The program of assistance to states for construction, renovation and remodeling of State Home facilities began on August 19, 1964, with the enactment of P.L. 88-450, which authorized annual appropriations of $5 million for making grants to State Homes by the DVA; in recent years this figure has grown to $42 million annually.

Section 201(b) of the reported bill would amend Section 5033(a) of title 38, U.S.C., by extending the State Home Grant Authority program three years through September 30, 1992. The committee is committed to maintaining this program as it is very successful in helping to meet the growing need for long-term care facilities.

Homeless Veterans.—There has been considerable hearing testimony, broadcast media reports, and editorials concerning the type and scope of problems relating to homeless persons. The number of homeless persons who suffer from chronic mental illness and the number of homeless persons who are eligible for veterans benefits are unknown, but most estimates suggest that many homeless may be eligible for veterans benefits and that a significant proportion of the homeless are chronically mentally ill. There is certainly evidence that the movement begun in the 1960's to "deinstitutionalize" patients in mental hospitals has resulted in a large number of homeless former mental patients. The absence of follow-up mechanisms and fragmented fiscal and management controls are, to a certain extent, thought to be responsible in part for the unhappy results of deinstitutionalization.

The comprehensive range of medical services furnished to eligible veterans by the Department of Veterans Affairs suggests the possibility of a more successful effort to address the medical and other needs of homelesss veterans. In Public Law 99-576, the Veterans' Benefits Improvement and Health Care Authorization Act of 1986, the Congress required the Department to submit a report to the Committees on Veterans Affairs on the implementation of the existing contract care authorities and expanded home health services authority for eligible chronically mentally ill veterans. In particular, the committees were interested in the demonstration project in Medical Region 1 of the DVA health care system to provide, when medically appropriate and otherwise feasible, community-based treatment services for eligible chronically mentally ill veterans. The success of this program was noteworthy.

Funds were provided for transfer to the veterans' medical care account of $5 million previously appropriated for fiscal year 1987, to carry out the new contract authority granted to the Department under Public Law 100-6 (section 2, Treatment and Rehabilitation for Chronically Mentally Ill Veterans, of Public Law 100-6, making emergency additional funds available for fiscal year 1987 for the Emergency Food and Shelter Program of the Federal Emergency Management Agency.) . Subsequently, this section was replaced under Public Law 100-322, the Veterans' Benefits and Services Act of 1988, with a one-year pilot program to provide community-based residential care to homeless chronically mentally ill veterans. There is evidence of the success of this pilot program. However, the one-year time frame set under Public Law 100-322 now appears insufficient to complete a comprehensive assessment.

Therefore, section 201(c) of the reported bill would extend for three years or until September 30, 1992, the authority to conduct the pilot program.

"Means Test" reporting requirement.—In 1986, Congress enacted Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985. Included in this law were the Veterans' Health Care Amendments of 1986 which provided for reform of veterans' eligibility for Department of Veterans Affairs medical care and authorized third-party recovery from health care insurers for nonservice-connected disabled veterans who obtain health care in DVA facilities. This so-called "means test" was implemented in response to budget reconciliation instructions to achieve specified cost-savings.

The law required the Secretary to provide the Committees on Veterans' Affairs of the Senate and House of Representatives with a report on the effects of the eligibility reforms contained in the bill. The law required three annual reports due by February 1 of 1987, 1988, and 1989, and required the numbers and characteristics of, and health care furnished to, veterans (and amounts of payments by them when appropriate) who are eligible for DVA care by reason of the new income threshold criteria, and the numbers of, and health care furnished to, veterans in each of the other categories of eligibility, with breakdowns, in the case of such veterans with service-connected disabilities, for each percentile disability rating.

Section 201(d) of the reported bill would extend the reporting requirement by 3 years, through the end of fiscal year 1992. The current budget situation facing the DVA medical care program presents numerous potential alternative actions by the DVA. Fundamental in making these decisions is accurate information regarding the operations of the medical care system. The committee believes that the report required under Public Law 99-272 contains much relevant data about the medical care system.

Special Post-Traumatic Stress Disorder Advisory Committee Reporting Requirement.—In 1980, the American Psychiatric Association's Diagnostic and Statistical Manual officially recognized Posttraumatic Stress Disorder (PTSD) as a diagnosis and identified combat as a potential stressor. At that time, because of the relatively recent acceptance by the medical community of this disorder, procedures for diagnosing and treating PTSD were not well established. In an effort to address the problems, a Special Committee on PTSD was established under Public Law 98-528 to advise the Chief Medical Director on diagnosis, treatment and a wide range of PTSD related issues.

Public Law 98-160 mandated in 1983 a study of the frequency of Post-Traumatic Stress Disorder and other post-war readjustment problems of Vietnam veterans. The results of the study were released in January of 1989 and showed that about 15.2 percent of male and 8.5 percent of female Vietnam theater veterans currently have PTSD. Currently, there are 194 Vet Centers; and 89 DVA medical centers have treatment programs specifically for PTSD. Approximately 20 percent of Vietnam veterans (about 100,000) have received treatment from the DVA through these programs.

Section 201(e) of the reported bill would extend the reporting requirement of the Advisory Committee for 3 years. In light of the significant number of veterans reported to be suffering from PTSD, the committee believes that the Special PTSD Committee's efforts in this area continue to be of value.

HOUSING PROGRAM AND COMPENSATED WORK THERAPY PROGRAM

The movement to deinstitutionalize psychiatric inpatients gained force in the 1950s and 1960s, having as its intent to provide psychiatric patients an opporutnity to go back into society. Yet, many of these patients did not receive the necessary medical and psychiatric care, food, shelter, and work therapy that had been available to them in the hospital. They were released to communities unprepared to care for them and often were institutionalized again in understaffed community nursing homes and jails.

During the last 20 years, the Department of Veterans Affairs has closed over 30,000 psychiatric beds. The lengths of stay for psychiatric patients have been reduced from about 54 days on the average in 1976 to 36.5 days on the average in 1986. Concurrently, the Department has placed an increasing emphasis on ambulatory care or outpatient programs. These trends are consistent with the changes in other psychiatric treatment programs.

Before the rise of the deinstitutionalization movement, the goal of patient work was to provide the labor necessary to maintain the institution. With the advent of deinstitutionalization, work became a therapeutic activity which increased the patient's capability to develop the psychosocial and vocational skills necessary for community reentry.

The Department of Veterans Affairs, in addition to the range of inpatient and outpatient treatment modes, is authorized to operate Compensated Work Therapy (CWT) programs under section 618(b) of title 38, U.S.C.. The programs are funded by a revolving fund known as the Special Therapeutic and Rehabilitation Activities Fund (STRAF). The purpose of these programs is to provide a clincial procedure for evaluating the patient's vocational or avocational interests, aptitudes, and skills, as well as assessing the patient's physical and mental capacities for work in actual employment situations. These programs encourage the development of good working habits, emphasizing attendance, reliabilty, punctuality, productivity, craftsmanship, and personal responsibilities. The major component is a work regimen with monetary incentives derived from work contracts, which under current regulations are developed with private industry or other sources outside the DVA.

CWT programs involve the use of work subcontracted from and paid for by industries. Wages are generally paid on a piece-work basis and are provided and generated through the work contracts. Jobs performed in CWT may range from simple packaging and salvaging type activities to fabrication and assembly operations using complex machines. Activities can take place in the medical center, in the community, or on the industrial site. In fiscal year 1987, there were 43 active CWT programs with 5,293 veterans assigned to the various work projects. A recent evaluation study conducted by the DVA's Office of Planning and Evaluation found the CWT programs to be successful. Specifically, the findings were: the programs are less resource intensive than other outpatient treatments; the programs are effective in facilitating timely and successful discharge from treatment and into the community; and the programs provide unique and otherwise unavailable service at the local level for mentally ill veterans. In addition, the General Accounting Office (GAO) and the DVA's Inspector General have found the programs to be cost-effective and to result in a positive therapeutic treatment.

Current law restricts contracting to "private industry or other sources outside the (DVA)". The DVA's General Counsel opines that such language also restricts contracting with other governmental agencies as well. The result is that in some areas of the country, particularly in rural areas, the opportunities for establishing CWT programs are foreclosed. A further restriction on the program is that the General Counsel has advised that the language in section 618(c)(1) restricts expenditures from the DVA's Special Therapeutic and Rehabilitation Activities Fund for the expenses of travel for training program employees at the local sites.

Work and treatment are not the only problems associated with chronically mentally ill patients in the context of helping them make the transition back into the community. The need for transitional or therapeutic living space is critical to the success of any of these therapeutic programs. The research literature is consistent in emphasizing the role of housing in successfully completing a deinstitutionalization program, no matter what the other therapeutic content of the program might be.

Sections 202 and 203 of the reported bill are designed to bring together some existing DVA programs, with certain modifications, in order to provide an opportunity for patients to consolidate their clinical improvement and develop sufficient skills and income to achieve maximum levels of independence. Specifically, patients will be involved in a therapeutic program which will combine the CWT program with therapeutic residential living prior to discharge to the community and which will be substantially self-supporting.

In addition, section 202 would authorize the Secretary to convey properties to persons who enter into agreements with the Department to employ patients who are part of the Department's CWT programs at not less than 75 percent of the fair market values of such properties.

Section 203 of the reported bill would allow for CWT programs to contract with an array of private and governmental entities, including the DVA. This will allow, particularly in rural areas, more opportunities to establish successful CWT programs. Further, section 203 would allow STRAF funds to be used for travel and for training of employees of the CWT program.

Section 203 also would authorize the Secretary to carry out a demonstration program of transitional housing. The demonstration program would be authorized for three years only for participants of the CWT program. Other requirements include: (1) veterans must pay rent to the therapeutic residence to be collected from their earnings; (2) veterans may be allowed to live in the therapeutic residences for a stated period of time to be determined by the Secretary; (3) veterans may remain in the therapeutic residence after completion of the CWT program only if they are receiving DVA outpatient services and are awaiting placement in community housing; (4) each therapeutic residence would have a house manager who could be provided room and board and possibly a minimal stipend in exchange for overseeing the residence.

ELIGIBILITY FOR MEDICAL SERVICES

The Veterans' Benefits and Services provisions of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, substantially changed eligibility for DVA medical services by requiring the DVA to provide needed hospital care for a category of eligible veterans that has come to be known as Category A. Category A veterans are: veterans with service-connected disabilities; former prisoners of war; veterans exposed to certain herbicides and ionizing radiation; veterans disabled as a result of DVA treatment or vocational rehabilitation; veterans of the Mexican border period or World War I; and non-service-connected veterans with one dependent whose income does not exceed $19,759, increased by $1,098 for each additional dependent, or $16,466 for a veteran with no dependents.

Under the provisions of Public Law 99-272, veterans other than those in Category A remained eligible for DVA hospital care with certain modifications. The modifications resulted in two groups of eligible veterans which are known as Category B and Category C. The DVA may provide needed hospital care to these veterans to the extent the DVA resources and facilities are available. Category B eligibility includes those non-service-connected veterans whose incomes exceed $16,467 (but do not exceed $21,954) for a single veteran and $19,760 (but do not exceed $27,443) for a veteran with one dependent plus $1,098 for each additional dependent. Category C eligibility includes those non-service-connected veterans whose incomes exceed $21,955 for a single veteran and $27,443 for a veteran with one dependent, plus $1,098 for each additional dependent; the DVA can provide needed hospital care to the extent that DVA resources and facilities are available and provided that the veteran agrees to pay a nominal fee.

Despite difficulties anticipated by the DVA, Public Law 99-272 was smoothly implemented. In its initial report to Congress and in follow-up reports, the proportion of care delivered to Category A veterans is approximately 94 percent; to Category B, approximately 3 percent; and to Category C, approximately 3 percent.

Public Law 99-272 did not change eligibility for outpatient care, nursing home care or other medical services, except to require that Category C eligible veterans pay a nominal fee in connection with the receipt of services.

As enacted, Public Law 100-322 required the DVA to furnish needed outpatient care for the service-connected disability of a veteran; for any disability of a veteran with a service-connected disability at 50 percent or more; and for veterans disabled as a result of DVA treatment or vocational rehabilitation. In addition, it requires the DVA to furnish outpatient care for the pre-hospital care, care to obviate the need for hospital care, and post-insitutional followup care for veterans having service-connected disabilities rated at 30 and 40 percent or for a veterans with an income at or below the pension aid-and-attendance income level. This law also revised the priorities for veterans for whom the DVA is not required to provide needed outpatient care.

Section 204 of the reported bill would require the DVA to provide outpatient care, except for dental services, to all Category A veterans for whom hospital care is mandated under section 610 title 38, U.S.C.. The reported bill would not change the eligibility for outpatient care for Category B and C eligible veterans.

By mandating health care to a limited, defined group, veterans would be able to predict the likelihood of receiving care from the DVA and the DVA and the Congress would have a basis for allocation of resources. The DVA is authorized to continue providing care to the extent possible to an additional group of veterans where space is available and, in certain cases, where the veteran voluntarily agrees to pay a certain fee in connection with the receipt of care. The committee believes that, instead of trying to shrink the pool of eligible veterans without any mandate to provide care for those veterans who remain eligible, the Federal Government should clearly identify those veterans who, as a matter of public policy, should receive health care, and mandate that they be provided care in DVA facilities.

In a directly related issue, the committee underscores the testimony presented in hearings that outpatient services are much less expensive than service provided on an inpatient basis. The committee perceives that a statutory entitlement only for hospital care may provide an incentive for delivering needed care on an inpatient basis. The mandate in the reported bill to provide needed outpatient care should neutralize this bias so that the locus for care can be decided on the basis of good medical judgment.

The committee anticipates that solidifying the DVA's authority to provide on an outpatient basis services which have heretofore necessarily been provided to inpatients only,m coupled with the lower cost of outpatient care, will allow the DVA to provide cost-effective services to more veterans.

NATIONAL PROGRAM FOR IMPROVED SYSTEM FOR COLLECTION OF FEES

P.L. 99-272 restated the right of the U.S. to recover the cost of certain care and services from third parties without substantive modification except for the addition of a new category of care for which recovery may be sought. The new category was for medical care provided to a veteran with no service-connected disability who is entitiled to care, or reimbursement for care, from a third party such as an employee health care insurer. This authority was in addition to the DVA's previous authority to collect under worker compensation laws, automobile "no-fault" insurance policies, and "victims of crime" compensation funds. Under P.L. 99-272, the monies recovered go to the Treasury of the United States and not to the DVA.

The DVA has unique constraints in responding to this change. For example, there is little incentive for medical centers to attempt recoveries due to the costs associated with recovery and the costs of assigning scarce staff to a function the benefits of which do not accrue to the facility. Also, billing and collection are new functions for the DVA and, historically, coordinating agencies (such as the Department of the Treasury, District Counsels, and the Department of Justice) have placed low priority on collections. Further, the DVA does not have reimbursement contracts with most major, private insurance companies.

A program was developed in the DVA's Medical Region 2 to increase revenues and collections from the provision of medical care at the Richmond medical center. The program defined legally permissible opportunities for such collections, taking into account the DVA's unique constraints and capabilities. The preliminary findings from the program indicate that this one medical center could: increase revenue by $419,000 if tort feasor cases were properly identified and pursued; increase inpatient billing revenue by $4.4 million at current billing rates if all non-service-connected patients with reimbursable insurance were identified; and increase revenues by modifying the charges billed by DVA facilities to local rates.

The program also identified benefits to be obtained through automating the collections. These included: more accurate billing information; interface with the DVA's existing Decentralized Hospital Computer Program (DHCP); timely generation of bills; ability to make inquiries on claims status for patient accounts; and speeding cash flow and reducing delays in accounts receivable. A recent letter from the Chief Benefits Director R.J. Vogel, points out the significant amount of money that can be saved through the implementation of effective methods of collection. In his letter, Mr. Vogel states that the DVA has collected $324 million from cash collection and offset of benefits in fiscal year 1988 and that dispositions were significantly increased in fiscal years 1986, 1987, and 1988. Due to these new and improved methods of collection, the DVA is pursuing fewer debtors with greater collections during the last 2 years.

Section 301 of the reported bill would require the DVA to carry out a program for the establishment of an improved management system for the administration and collection of fees and other amounts payable to the United States under the DVA receipts program. For purposes of this section, those amounts that are to be included in collections are fees charged to third parties, amounts recoverable under section 629 of title 38, U.S.C., and amounts payable as first-party medical copayments authorized in such title.

As part of the proposed system, the Secretary would be required to provide for the development of an automated program to carry out billing and collection of fees and other amounts. In developing the billing and collection program, the Secretary would have to use services of the private sector to the maximum extent feasible.

In order for the Congress to monitor the effectiveness of the program, not later than January 31, 1992, the Secretary would be required to submit to the Committees on Veterans' Affairs of the House and Senate a report on the operation of this program during fiscal years 1990 and 1991. The report shall be based on a study comparing (1) the experience of carrying out this program through the use of employees of the DVA at not more than 20 medical centers with (2) the experience of carrying out the above provisions through the use of contractor services at not more than 20 medical centers.

The Secretary would be required to defray the costs of administering the automated program, including the costs of any contract under this program, from the amounts received by the Secretary through the program. Of the amounts that remain after administrative costs are defrayed, the Secretary would be rquired to transfer into the general fund of the Treasury as miscellaneous receipts an amount equal to the amount which was estimated by CBO in February 1989 to be the total amount which would be recovered or collected for fiscal year 1990 assuming that this section had not been enacted.

The Secretary would be required to allocate the remaining amounts as follows: (1) 50-percent shall be credited to the Medical Care Account of the DVA; (2) 50-percent shall be credited to the Nursing Home Revolving Fund of the DVA. The committee is aware that certain medical centers have carried out collections procedures in an outstanding manner, while others have assigned little attention to the activity. Thus, the potential for increased collections under the proposed program are proportionately reduced for the former medical centers. The committee intends that the Secretary would prescribe under the required regulations a method to allocate to the medical centers the 50 percent of collections to be retained in such a way as to avoid penalizing those medical centers which, prior to the implementation of this program, were performing the collections process well. It is further the intent of the committee that the regulations provide real incentives to directors of the medical centers to increase recovery of amounts owed and that the Central Office not retain these funds for its own purposes.

The committee believes that the opportunity should be taken to learn from the private sector in this matter. The incentives provided in this provision should not only serve to enhance the revenues generated by the recovery authority in law, but should also serve to alleviate some of the fiscal problems of the DVA medical program.

ELIGIBILITY OF MILITARY DEPENDENTS FOR HEALTH CARE UNDER SHARING AGREEMENTS

In general, the DVA is required to provide hospital care and outpatient care for certain categories of veterans. In addition, the DVA may provide hospital and outpatient care on a space available basis to other eligible veterans. The DVA also acts as a backup to the Department of Defense (DOD) in case of national emergency.

The DOD health care system has two primary objectives. The first is to maintain the health of the active duty force, and the second is to provide medical care to eligible dependents and retirees when space, facilities, and staff are available. Active duty members of the uniformed services have first priority for care in military medical facilities. Care provided in military treatment facilities to other uniformed services' beneficiaries—dependents—is provided on a space available basis.

Under P.L. 97-174, the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, an individual who is a primary beneficiary of the agency may be provided health care at the facility of the other agency that is a party to the sharing agreement. However, under current law, DOD dependents are not allowed to receive medical treatment in DVA facilities. Under the DVA's 1986 interpretation of that law, the sharing law grants broad authority for DVA to provide services to DOD; the only limitation is on providing health care to DOD dependents or other non-primary beneficiaries.

Bills were introduced in the House and Senate in 1986 and another bill was introduced in the House in 1987 to remove the restriction regarding DVA treating DOD dependents under DVA/DOD sharing agreements. No action was taken on these bills. In a recent report, GAO recommended to Congress legislation that would extend DVA/DOD sharing authority to any individual eligible to receive health care at either DVA or DOD facilities on a space available, referral basis. This legislation would improve the efficiency and reduce the costs of DVA and DOD hospitals by expanding the authority to share health care resources. DVA and DOD concurred in that recommendation.

Section 302 of the reported bill would authorize dependents of members of the active duty armed forces to receive health care in DVA facilities in instances where sharing agreements are in force. The committee intends that care provided to such dependents be on a space available, referral basis, as section 5011(c) of title 38 U.S.C., currently permits the provision of direct health care to any DOD beneficiary only if the care does not adversely affect the range of service, quality of care, or the established priorities for care provided to eligible veterans. Thus, admission of dependents under this section would not displace veterans.

The committee remains committed to the DVA/DOD sharing program as it has proved its efficiency and effectiveness for both departments. An example of this can be seen in Albuquerque, New Mexico, where the Air Force occupies the sixth floor of the new DVA hospital and is operating 40 beds. The DVA provides all ancillary support to the in-house Air Force staff. Tertiary care for Air Force beneficiaries is either purchased from the DVA or from the community. The Air Force manages the emergency room and a new Air Force outpatient clinic has been constructed next to the hospital. Another example is Las Vegas, Nevada where the DVA has agreed to share in the construction costs and use of a new Nellis Air Force Base Hospital. The joint venture hospital is scheduled for occupancy in fiscal year 1993. The DVA will have 52 of 129 hospital beds. There will be many opportunities for savings which involve shared equipment purchases, consolidated procurement of supplies, and sharing of scarce clinical specialists.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE VETERANS' ADMINISTRATION (CHAMPVA)

Initially authorized in 1973, the Civilian Health and Medical Program of the Veterans' Administration (CHAMPVA) customarily operates as a health care insurance program and provides payment of 75 percent of the cost of inpatient and outpatient health care furnished to eligible dependents of certain veterans. These individuals include dependents of veterans who are permanently and totally service-connected disabled, dependents of deceased veterans who were rated permanently and totally service-connected disabled at the time of their death from non-service-connected causes, and the survivors of veterans who have died as a result of a service-connected condition. CHAMPVA beneficiaries generally obtain health care from private health care providers and pay 25 percent of the cost of care received.

Claims for CHAMPVA benefits are submitted either by the beneficiary or the service provider to a financial intermediary who processes and pays the claim on behalf of the DVA. The DVA provides reimbursements to financial intermediaries for payment of claims for care provided to program beneficiaries, and makes payments for costs associated with the processing of benefits claims and the administration of the program.

On March 17, 1988, the committee conducted a hearing to examine the current effectiveness and efficiency of the administration of CHAMPVA by the Department. According to testimony and information presented to the committee, the administration of CHAMPVA has been marked by serious continuing deficiencies.

According to audits conducted by the DVA's Office of Inspector General (OIG), an estimated 15 percent of all CHAMPVA program beneficiaries in 1986 were considered to be ineligible. This is about 28.3 percent of the individuals who received CHAMPVA benefits (56,601 of 200,083). During the four year fiscal period from 1983–1986, an estimated $40.7 million was spent for CHAMPVA, health and medical care benefit claims on behalf of persons not eligible for CHAMPVA and an additional $2.2 million in associated CHAMPVA administrative costs was paid. According to the Inspector General, DVA spending for individuals not eligible for CHAMPVA program benefits was projected to be $29.7 million during fiscal years 1987 and 1988.

The committee believes action must be taken promptly by the Department to correct serious deficiencies which have been identified in the administration of CHAMPVA. The provisions reported by the committee in section 303 of the reported bill would require action to be taken to correct serious program administrative deficiencies and to improve the cost effectiveness and efficiency of the administration of this benefit program.

Specifically, section 303 of the reported bill would require the Secretary of Veterans Affairs to: (1) compile an accurate and complete list of individuals who are eligible as of October 1, 1989 to receive benefits under Section 613 of title 38; (2) compile this list not later than October 1, 1989; and (3) maintain and periodically revise this list of eligible program beneficiaries. In addition, section 303 would require the Secretary to establish not later than October 1, 1989, a procedure for the review of the need, cost effectiveness, and appropriateness of the health care provided by the DVA under Section 613 of such title.

Section 303 would direct the DVA's Inspector General to submit to the Committees on Veterans' Affairs of the Senate and of the House of Representatives a report on the Secretary's compliance with this section. If the DVA's Office of Inspector General finds that the Secretary has not complied with requirements of these subsections, the Secretary would be required to submit a report explaining the reasons for non-compliance and a plan to correct the deficiency.

Section 303 would also require the Secretary to conduct a study of alternative methods for providing for the cost of health care currently authorized under section 613 of such title. In carrying out the study, the Secretary shall consider methods which would result in a substantially unchanged cost to the U.S. while providing improved health care benefits at lower costs to beneficiaries. This section also directs the Secretary to submit a report on the results of the study to Congress no later than one year after the date of enactment of this Act. It further authorizes the appropriation of $500,000 to carry out the study directed by this subsection.

VETERANS' CANTEEN SERVICE

Following an investigation of the services provided to hospitalized veterans by private concessionaires, the Veterans' Canteen Service was established in 1946 by P.L. 636, 79th Congress at the request of the then-Administrator, General Omar N. Bradley. Conducted in response to many complaints, this investigation found services provided to veterans by private concessionaires were inadequate and unsatisfactory and that veterans were being exploited financially because of excessive prices charged by private concessionaires for many canteen items.

Established as an independent entity within the DVA, the Veterans' Canteen Service (VCS) makes available to hospitalized and domiciled veterans, at reasonable prices, articles of merchandise and services which are essential to the comfort and well-being of these veterans. Financially self-sustaining, Congress provides no funds for the Veterans' Canteen Service. As a non-appropriated fund activity which is financially independent, the Veterans' Canteen Service generates funds needed for current operating expenses and capital investment from Canteen activities and operations. Further, under the provisions of P.L. 100-322, employees of the Veterans' Canteen Service are not to be considered employees of the DVA for the purpose of any personnel ceiling which may be applied to the DVA by the President.

The committee conducted three oversight hearings on the Veterans' Canteen Service, with the most recent on June 23, 1988. During this hearing, witnesses reported the DVA had ordered a fully operational resumption, effective June 7, 1988, of the process for soliciting bids for contracting out Canteen food service activities under the provisions of OMB Circular A-76. According to information presented to the committee, bids for contracting out food service activities in 74 Canteens are to be solicited. Eight of those Canteens were included in the first bid solicitation issued on August 15, 1988.

For the past several years, the Committee on Veterans' Affairs has opposed the mandatory contracting out of certain services to private contractors under OMB Circular A-76. In the view of the Committee on Veterans' Affairs, proposals to contract out Canteen activities or operations are based on the false assumptions that Government appropriations could be reduced on the one hand and services improved on the other. As already noted, Congress appropriates no funds for the Veterans' Canteen Service; VCS operations pay their own way and inclusion of VCS activities in the A-76 process will not reduce Federal appropriations. The VCS employs its own personnel, pays their salaries, retirement and other employment benefits and purchases goods through a revolving fund established by law. To return to the use of contractors for the VCS food operations or other activities would turn back the clock some 40 years and would do a disservice to veteran patients, their families, and visitors, as well as DVA employees utilizing these services.

Therefore, section 304 of the reported bill would amend section 4203 of title 38, to prohibit securing by contract or agreement the performance of a VCS activity by an individual not directly employed by the United States, when such an activity is being performed by an employee of the United States who is compensated with non-appropriated funds.

As noted previously, the VCS is an independent entity within the DVA. As provided in section 4208, title 38, the VCS "under control and supervision of the Administrator, shall function as an independent unit in the DVA and shall have exclusive control over all its activities, including sales, procurement and supply, finance including disbursements and personnel management . . ." Witnesses who appeared at the June 23, 1988 hearing testified that VCS Central Office employees were now reporting to the Veterans Health Services and Research Administration (VHS&RA) officials, including the Director of Administration, on VCS activities and policies including merchandising and the purchasing and pricing of articles and other items offered for sale. In response to a separate inquiry, the DVA also acknowledged that VCS employees regularly report to VHS&RA officials on VCS activities and operations.

The requiring of daily reports to the VHS&RA officials by the VCS employees regarding Canteen activities and operations is inconsistent with the exclusive control and operational independence provided to the VCS by Congress. Therefore, section 304(b) of the reported bill would amend section 4208, title 38, to prohibit the head of the VCS from being required to report to or be supervised by any official of the Department other than the Secretary or the Deputy Secretary.

COMMUNITY NURSING HOMES

On April 21, 1988, the Department of Veterans Affairs issued final regulations concerning the conditions under which an extension of nursing home care may be granted. (FR 13120, Vol. 53, number 77 April 21, 1988.) Previously, non-service-connected disabled veterans were authorized under section 620(a) of title 38, U.S.C. to receive community nursing home care at DVA expense for six months in the aggregate except in three general cases, one of which is "in a case in which, in the judgment of the Secretary, a longer period of nursing home care is warranted." No criteria were specified in the statute or in regulation. The new regulation contains such criteria and, further, sets an arbitrary 45-day limit as to the length of any extension.

Section 305 of the reported bill would rescind the new regulation and replace it with the previous regulation.

PROSTHETICS AND SENSORY AIDS

The purpose of the committee's "Survey Of Veterans' Administration Medical Centers" was to establish the condition of the DVA in terms of its fiscal health. Recent reports to the committee had indicated that the DVA health care delivery system was in a state of serious financial crisis. The Survey confirmed these allegations. Operating beds had been closed due to staff shortages. The stopgap solution to address the shortages of health care personnel was the transferring of monies from other operating accounts, including prosthetics, to fund personnel costs.

Specifically, the Survey found that medical center directors were literally raiding other accounts to meet unfunded requirements in recurring operating expenses. It was reported that over $44 million had been taken from drugs, medical supplies and prosthetics monies. That is an average of $411,250 for each medical center.

On September 7, 1988, the House Committee on Veterans' Affairs, Subcommittee on Hospitals and Health Care, held a hearing on the status of the Department's medical care system. The committee received testimony from representatives of veterans' service organizations as well as DVA medical center directors and DVA central office personnel. The testimony illuminated the severity of the problems associated with the provision of prosthetics to veterans. The hearing identified a growing problem with delays in the provision of prosthetic devices and appliances which are essential to the veteran, in many instances. The committee heard reports that delivery of items such as artificial limbs, wheelchairs, and other equipment were being delayed weeks and in some instances months. Applications for prosthetic items were backlogged at many medical centers. There were instances where veterans were being held in the hospital due to an inability of the medical center to discharge the veteran because of shortages of essential items necessary for daily living.

The results of this hearing made it clear that the shifting of funds during the fiscal year from the amount budgeted for prosthetic supplies and equipment was having a detrimental effect on the ability of the DVA to provide needed services to eligible veterans. Specifically, lengthy delays have been experienced by eligible veterans in obtaining needed services.

On April 26, 1989, the Subcommittee on Hospitals and Health Care held an additional hearing on the matter. The Subcommittee received testimony from Mr. Frederick Downs, Jr., Director of the DVA's Prosthetic and Sensory Aids Service. His testimony verified that the problems identified in 1988 were still occurring. In addition, Mr. Downs documented that no Departmental staffing plan exists. Thus, some DVA facilities with large eligible populations may have too few, or no prosthetics representatives. The Department also has no education program to ensure that prosthetics representatives are trained initially and kept up to date on new developments and techniques.

Therefore, section 306 of the reported bill would require the Secretary to establish staffing standards based on the number of eligible veterans seeking prosthetics and sensory aids services from DVA medical facilities. In addition, section 306 would require the Secretary to carry out a program of training and continuing education of prosthetics representatives, orthotists, prosthetists, and other health care personnel involved in providing prosthetics and sensory aids services.

Finally, section 306 would require the Secretary to submit a report to the Committees on Veterans' Affairs of the Senate and House of Representatives on the funding and operation of the Department's prosthetics program. Specific description and analysis of delays between ordering and receiving prosthetic services and reasons for delays would be required to be included in the report.

The committee expects to use this report to ensure timely, high-quality provision of prosthetic and sensory aids services to the highest priority veterans, those with service-connected disabilities. The reporting requirement authorized in section 306 would enable the committee to monitor the actual status of the funding of prosthetic services. In so doing, the committee will be able to carry out its oversight function with regard to the reported delays and reductions in service.

The committee intends that this provision will provide the stimulus to the Department of Veterans Affairs to assign a higher priority to the provision of Prosthetic Services to our Nation's veterans.

SECTION-BY-SECTION ANALYSIS

H.R. 901

Section 101.—Section 101 would amend 38 U.S.C.§ 4107(e) to require that licensed practical or vocational nurses, and nursing assistants, receive the same premium pay as registered nurses.

Section 102.—Section 102 would amend 38 U.S.C. § 4108. It is intended to clarify that employees in the so-called "hybrid" health-care professions who are appointed under 38 U.S.C. § 4104(3) (clinical or counseling psychologists, respiratory therapists, licensed physical therapists, licensed practical or vocational nurses, pharmacists, and occupational therapists) are not subject to the provisions of section 4108 which prohibit remunerated outside clinical employment.

Section 103.—Section 103 would amend 38 U.S.C. § 4107(i) to expand VA's existing authority to grant exceptions to a required reduction in retired military pay so as to include registered nurses. Section 5532 of title 5, United States Code, now imposes upon retired officers of the uniformed services, a substantial reduction in their retired pay when appointed to civilian positions in the Federal Government. Under that section, the former officer's retired pay, following appointment, is reduced to an amount equal to $7,698.51 plus half the remainder of his retired pay. The law also imposes an overall effective ceiling equivalent to Executive Level V ($75,500) of the combined retired pay and civilian pay. VA now has authority in 38 U.S.C. § 4107(i) to authorize exceptions to the statutory loss of pay for well-qualified physicians. To help with recruitment and retention problems, particularly with registered nurses, this section would allow the same exceptions for registered nurse positions.

Section 104.—Section 104 would add a new subsection to 38 U.S.C. § 4107 to permit waiver of the statutory cap on physician pay in cases involving specific physician positions which the Secretary determines are in a specialty which is extremely difficult to recruit and retain. Current law limits the pay of VA physicians, excluding special pay under 38 U.S.C. § 4118, to that paid to individuals in Level V of the Executive Schedule, currently $75,500. This section would allow waiver of that cap in a further effort to help VA obtain the critically needed services of these physicians.

Section 105.—Section 105 would amend 38 U.S.C. § 4106 to authorize VA to appoint graduates of affiliated allied health-care education programs to competitive civil servicepositions without regard to competitive civil service procedures. Under its statutory health-care education mission, VA operates clinical education programs in its facilities which annually train approximately 50,000 students in allied health-care occupations, including psychology, social work, audiology, speech therapy, dietetics and recreational therapy. The complicated and often lengthy civil service process discourages many highly-qualified allied health-care graduates of VA-affiliated clinical education programs from taking jobs with the VA. By the time these graduates complete the process for placement on a civil service register, and are certified to the VA, other health care employers have often already hired them. This proposal will enable VA, without jeopardizing merit principles, to directly hire graduates of proven competence, who already are familiar with VA methods, without regard to the competitive service certification process. Current qualifi- cation standards would continue to apply. Jurisdiction of adverse action appeals from employees appointed under this authority would continue in the Merit Systems Protection Board.

Section 106.—Section 106 would add a new subsection to 38μU.S.C. § 4108 to authorize the Secretary of Veterans Affairs to carry out a leave-sharing program for title 38 employees. It would permit those individuals who face medical emergencies involving themselves or their family members to use the leave of other individuals and thus help them avoid the threat of loss of pay because leave resources have become exhausted. The bill requires that the leave-sharing program be consistent with OPM administered leave-sharing programs for title 5 employees.

Section 201.—Section 201 would extend the authority for three valuable VA programs. First, it would amend 38 U.S.C. § 620B to provide ongoing authority for VA's respite care program, authority which now expires on September 30, 1989. Respite care services allow VA to provide chronically ill veterans who reside at home with brief, planned periods of care in VA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. The program allows veterans to remain at home in the care of their loved ones, rather than requiring them to be institutionalized for protracted periods. Second, the section would amend 38 U.S.C. § 5033(a) to authorize appropriations for the State home grant program for three years, through September 30, 1992. That program provides grant support to States to assist in the construction or acquisition of State home facilities for veterans. Third, section 201 would amend section 115(d) of Public Law 100-322 to extend for three years to September 30, 1992, the VA's program for Homeless Chronically Mentally Ill (HCMI) veterans. That program provides residentialcare and treatment of those veterans through contracts with community based institutions.

Section 201 would also direct VA to continue reporting to the Congressional Veterans' Affairs Committees on two other VA programs. First, it would amend section 19011(e)(1) of Public Law 99-272 to require VA to submit reports on implementation of the so-called "means test" law for the years 1990, 1991 and 1992. Second, it would amend section 110(e)(2) of Public Law 98-528 to require VA to continue submitting annual reports through 1991 on its activities related to providing care for PTSD and on the activities of the VA's Special Committee on PTSD.

Section 202.—Section 202 would amend section 9 of the Veterans' Home Loan Program Improvements Act of 1987, Public Law 100-198 (38μU.S.C. § 1820 note) to authorize the Secretary to convey, at a discount, real property obtained as a result of defaults on loans made or guaranteed by the VA, to persons who contract with VA to employ veterans as part of the compensated work therapy (CWT) program. Public Law 100-198 authorized the Department to convey this type of property, under certain conditions, to non-profit organizations and State and local Governments, to assist them in providing housing for homeless veterans and their families. Section 202 would extend that authority to permit similar sales to for-profit and non-profit entities which contract with VA to provide CWT activities for VA's patients.

Section 203.—Section 203(a) would amend 38 U.S.C. § 618(b)(1) to broaden VA's authority to obtain therapeutic work for patients participating in CWT programs. Current law permits VA CWT programs to contract for therapeutic work for patients only with non-Federal entities (primarily private profitmaking businesses) to obtain the needed therapeutic work projects for CWT participants. However, opportunities for work exist in VA facilities and other Federal entities, particularly at smaller facilities in more rural areas of the country. This proposal would permit arrangements, contractual or otherwise, with any appropriate source of work, including VA facilities and other Federal entities, greatly enhancing VA's ability to provide patients with these valuable therapeutic work experiences.

Section 203(b) would amend 38 U.S.C. § 618 to authorize VA to conduct a demonstration program under which the Department would provide therapeutic transitional housing to veterans participating in VA compensated work therapy programs. Under the pilot program, the Secretary would purchase, lease, or otherwise acquire residential housing in which eligible veterans (only those participating in incentive therapy or compensated work therapy) would live together with a house manager. The measure would require compliance with local zoning, building permit, and fire and safety requirements applicable to residential property in the community. The bill would direct that each resident would pay rent, except for the house manager, who would be a VA contractor and who could receive free room and board in addition to any fee for services. The law would permit VA to acquire and use any suitable housing facility including houses VA or HUD owns as a result of defaults on loans made or guaranteed by either of those Federal agencies. If houses are obtained from VA or HUD, the Secretary would have to transfer funds from the VA's Special Therapeutics and Rehabilitation Activities Fund (STRAF) to the VA's Loan Guaranty Revolving Fund, or to HUD, as applicable, in an amount equal towhat either VA or HUD would charge for sale of the house to a nonprofit organization or a state for use as a shelter for homeless persons. The bill would also permit use of funds in the STRAF for acquisition, operation, and disposition of the transitional housing, and would provide that all rents from residents in the housing, and the proceeds from sales on any such housing, shall also be deposited in the STRAF.

Section 204.—Section 204 would amend 38 U.S.C. § 612 to direct that VA "shall" provide comprehensive outpatient treatment to all so-called "category A" veterans. Under current law, VA must provide hospital care to a specified group of veterans commonly referred to as those with "category A" eligibility. However, the law requires provision of comprehensive outpatient services only for any veteran needing care for a service-connected condition, and for any disability of any veteran who is 50% or more service-connected disabled. This proposal would direct that VA provide comprehensive outpatient care to the other veterans included in "category A". That would make eligibility for outpatient care consistent with eligibility for hospital care.

Section 301.—Section 301 would direct that VA conduct a program using an automated system for billing and collection of fees payable to the Government in connection with several programs administered by the Veterans Health Services and Research Administration (VHS&RA). The program would apply to fees VA charges to third parties, amounts it may recover from insurance companies or other third party payors for care furnished to veterans, and copayments veterans agree to pay to receive VA care. Under the program, the Secretary must use services of the private sector to the maximum extent feasible. To help ascertain the best type of collection system, the section would also require that the Secretary conduct a study in consultation with the GAO, comparing the collection experience at not more than 20 medical centers using VA employees, with the collection experience using contractor services at not more than 20 medical centers. A report on the study must be submitted to the Veterans Affairs committees of Congress by January 31, 1992.

Section 301 would also direct how VA must allocate the funds collected under the program. The allocation scheme is designed in part to provide incentives to VA medical centers to increasecollections. The Secretary must first use collected funds to defray the costs of administering the program, including thecosts of any contracts with private sector entities. Next, the Secretary must cover into the Treasury as miscellaneous receipts, all funds collected up to the amount the Congressional Budget Office has estimated that VA will collect in Fiscal Year 1990. If in any year VA collects amounts greater than the Congressional Budget Office has estimated for Fiscal Year 1990, those funds could be retained by VA. Fifty percent of any such excess should, under regulations the Secretary must prescribe, be allocated to the collecting medical centers to provide incentives for increased collections. The other fifty percent would be credited to VA's Nursing Home Revolving Fund.

Section 302.—Section 302 would amend 38 U.S.C. § 5011 to remove a restriction which precludes VA health-care facilities from providing health-care services to DoD dependents under VA/DoD sharing agreements. This change in the law would permit VA to use any excess capacity it may have to care for these individuals, and be fully reimbursed by DoD for the care it provides.

Section 303.—Section 303 would require VA to compile and maintain a complete and accurate list of persons eligible for CHAMPVA benefits by October 1, 1989, and require the Department to establish procedures for periodic review of the cost-effectiveness and appropriateness of health care provided. It also would charge the VA's Inspector General to report to the Committees on Veterans' Affairs regarding compliance with these measures, and require the Secretary to report on and correct any deficiencies. Finally, it would require VA to study alternative methods for providing the cost of health care to CHAMPVA beneficiaries, and report on those alternatives within a year of enactment of this statute. The provision would authorize the appropriation of $500,000 to carry out this study.

Section 304.—Section 304 would amend 38 U.S.C. § 4203, the Veterans Canteen Service statute, to prohibit the Service from contracting out performance of any activity otherwise performed by a Federal employee compensated from non-appropriated funds. Section 304 would also amend 38 U.S.C. § 4208 to provide that the head of VA's Canteen Service may not be required to report to or be supervised by any official other than the Secretary or Deputy Secretary.

Section 305.—Section 305 addresses the VA's authority to extend beyond a six-month limit the duration of contract nursing home care provided to nonservice-connected veterans. It would rescind an April 1988 change VA made to its regulations to place limitations on the duration of such extensions. Community nursing home care is intended to provide nonservice-connected veterans with up to six months of care during the period following discharge from hospital care when the veteran is making the transition from hospital care back to the community. Although six months of care is usually sufficient, there are occasions when an extension of care is needed if arrangements have not been completed for care of the veteran through non-VA sources.

Section 306.—Section 306 would add a new subsection to 38μU.S.C. § 5023; it is intended to help correct problems the Department has had with delays in providing prosthetics services. The new provision would direct the Secretary to develop staffing standards, based on the number of veterans seeking prosthetics services, calling for each facility needing a Prosthetic and Sensory Aides Service to have one that is adequately staffed with qualified representatives who are themselves disabled. It would also direct the conduct of training programs for health-care personnel providing prosthetic services. Finally, the section would require the Secretary to annually provide a detailed report to the Veterans Affairs Committees of Congress regarding all aspects of delays that have occurred in providing prosthetic appliances, actions taken to correct those delays, the numbers of facilities with qualified prosthetic representatives, and the training provided to persons providing prosthetic services.

OVERSIGHT FINDINGS

No oversight findings have been submitted to the committee by the Committee on Government Operations.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

The Committee received the following letter from the Congressional Budget Office concerning the cost of the reported bill:

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Robert D. Reischauer
Director

June 23, 1989

Honorable G. V. Montgomery
Chairman
House Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the attached cost estimate for H.R. 901, the Veterans' Health-Care Program Amendments of 1989, as ordered reported by the House Committee on Veterans Affairs, June 20, 1989.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

Robert D. Reischauer

cc. Honorable Bob Stump
Ranking Minority Member

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 23,1989

1. BILL NUMBER: H.R.901

2. BILL TITLE:

   Veterans' Health-Care Programs Amendments of 1989.

3. BILL STATUS:

   As ordered reported by the House Committee on Veterans' Affairs, June 20, 1989.

4. BILL PURPOSE:

   To extend certain expiring veterans' programs, to require the VA to provide outpatient care to all veterans who are entitled to VA hospital care, and for other purposes.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Estimated Authorization Level	125	133	142	85	92
Outlays	70	96	116	121	129

The cost of this bill would fall in budget function 700.

Basis of Estimate

The following section-by-section cost analysis addresses only those sections of the bill that could be expected to have a significant impact on the federal budget.

Section 101. Under current law, registered nurses are paid 125 percent of basic pay for workhours on Saturday or Sunday. This section would extend Saturday and Sunday premium pay to licensed practical nurses (LPNs), licensed vocational nurses (LVNs), and nursing assistants (NAs). Some LPNs and LVNs already receive premium pay under VA's authority to grant it where necessary for recruitment and retention of staff.

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Estimated Authorization Level	17	18	19	20	21
Outlays	16	18	19	20	21

According to VA data, there are around 10,900 LPNs and LVNs and 15,500 NAs in the VA system. Of this number, approximately 20 percent are receiving premium pay under the special authority. The average increase in pay for Saturday and Sunday work is estimated at $2.15 an hour for LPNs and LVNs and $2.00 an hour for NAs. These amounts are increased in the outyears for assumed federal payraises.

Section 104. This section would allow the VA to increase basic pay for certain physician specialties above the Executive Schedule level V pay cap. This authority would apply only to physician specialties with extreme recruitment and retention problems as determined by the Secretary.

The VA has not yet determined the manner in which this authority would be implemented, so it is not possible to make a precise estimate of the cost of section 104. The Committee report language states that the increased pay should be used to avoid the necessity of contracting for physician services, since the cost of contracting is higher than the cost of the direct employment of physicians.

There are five medical specialties in which the VA has severe recruitment and retention difficulties. They are anesthesiology, orthopedic surgery, pathology, physiatry, and radiology. In 1988, the VA contracted for 133 FTEE in physician services in these specialties. If the VA uses the authority to increase basic pay only to the extent necessary to replace the doctors working under contract with doctors working directly for the VA, there should not be a significant cost to this provision.

However, there are also 1,347 full-time and 905 part-time VA physicians working in these five specialties. If the VA found it necessary to increase salaries of these doctors as well in order to maintain staffing, the cost of this provision could be as high as $20-30 million.

Section 106. This section would require the VA to establish a voluntary leave transfer program for VA health-care professionals who are authorized under title 38, U.S.C., rather than under title 5.

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Estimated Authorization Level	2	2	2	2	2
Outlays	2	2	2	2	2

During the last part of fiscal year 1988, the Office of Personnel Management (OPM) conducted a government-wide pilot program of voluntary leave sharing. All agencies were allowed to participate, though none were required to. At least 71 agencies took part in the program and reported their results to OPM, covering, on the average, one quarter of the fiscal year. According to these OPM reports, approximately 391,000 hours of leave were voluntarily donated to 1,969 employees.

If OPM's initial experience is duplicated in the VA, approximately 450 title 38 employees would each be expected to utilize an average of 200 hours of donated leave per year in lieu of taking leave without pay. This estimate could be understated if the usage of the VA program is significantly greater than OPM's experience in the pilot program.

Section 201(a). This section would repeal the September 30, 1989 termination date for the respite care program. The respite care program provides up to 30 days of inpatient care per year to chronically ill veterans who are being cared for at home. These inpatient stays provide a respite to the caregiver from the stress of caring for the chronically ill veteran.

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Estimated Authorization Level	7	8	8	8	9
Outlays	6	8	8	8	9

According to VA data, approximately 1,800 individuals were provided respite care in 1988, and it is expected that the demand for care would remain fairly stable at this level in the future. However, the VA did not collect data on the number of days of respite care provided or the cost of care. The above estimate assumes that all individuals would receive the legal maximum of 30 days of care per year. Because respite care is provided in a nursing home in the vast majority of cases, the average per diem cost of VA nursing home care was used to calculate the cost of respite care. Costs were increased in the outyears for anticipated inflation.

Section 201(b). This section would authorize the appropriation of such sums as may be necessary for grants to states for the construction of state veterans' homes for fiscal years 1990-1992.

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Estimated Authorization Level	44	46	48	0	0
Outlays	0	9	22	34	37

The authorization level was estimated by increasing the 1989 appropriation for this program by the GNP deflator to account for anticipated inflation. These funds were assumed to spend out according to the historical spending patterns of the account.

Section 201(c). This section would extend for three years the authority of the VA to provide contract community residential care for veterans with chronic mental illnesses.

	(by fiscal years, in millions of dollars)				
	1990	1991	1992	1993	1994
Estimated Authorization Level	14	14	15	0	0
Outlays	12	14	15	2	0

The authorization level was estimated by increasing the 1989 appropriation for this activity by the GNP deflator to account for anticipated inflation. These funds were assumed to spend out according to historical spending patterns.

Section 202. This section would expand the program under which the VA is authorized to sell at a discount real property that the agency has acquired through foreclosures of VA-guaranteed loans. The VA is currently authorized to make discounted sales to organizations assisting homeless veterans if the property is to be used solely as a shelter. This section would also allow such sales for use as transitional housing.

According to the VA, the real property in their inventory -- almost entirely single-unit dwellings -- is not very well suited to the needs of homeless organizations. As a result, they have sold only one property, a four-unit building in Pittsburgh, under the current discount authority. It is not expected that the expansion of authority contained in section 202 would generate a sufficient number of additional sales to result in a significant cost.

Section 203. This section would authorize the VA to conduct a demonstration program to provide transitional housing to veterans who are currently patients in VA facilities and who are participants in therapeutic work programs. Funds to purchase or lease and maintain residences would be taken from the Special Therapeutic and Rehabilitative Activities Fund.

The Special Therapeutic and Rehabilitative Activities Fund has an unobligated balance of approximately $1 million. This would be the maximum amount that could be spent to acquire residences for transitional housing. Because there are other activities to be financed from the Fund's balances, and because the VA is unlikely to spend the entire reserve in one year, it is estimated that annual expenditures on the demonstration program would be less than $500,000.

Section 204. This section would require the VA to provide outpatient care to veterans who are entitled to VA hospital care (Category A veterans).

	(by fiscal years, in millions of dollars) 1990	1991	1992	1993	1994
Estimated Authorization Level	40	45	50	55	60
Outlays	34	45	50	55	60

This section would provide entitlement to all needed VA outpatient care to Category A veterans, a group currently eligible for such care with some limitations. Medical eligibility category "A" includes veterans with service-connected disabilities, former prisoners of war, and poor veterans, among others. Under current law, only veterans with service-connected disabilities rated 50 percent disabling or greater are eligible for all needed outpatient care. Other Category A veterans are eligible for pre- and post-hospital care and care that would obviate the need for inpatient care. The overwhelming majority of applications for outpatient care can be classified under one of these headings. Under section 204, however, all Category A veterans would be granted entitlement to all necessary outpatient care provided in VA facilities.

According to the VA General Counsel's staff, the effect of this bill on the VA system would be that, in those facilities where VA resources are inadequate to meet the demand for outpatient care from Category A veterans, the agency would be required to expand resources as necessary to meet that demand. It was assumed that this would be accomplished by extending the hours of operation of overcrowded outpatient clinics.

According to VA statistics on the disposition of applications for medical care, only about 0.4 percent of all Category A applicants for outpatient care are denied care for reasons that would be eliminated by this bill. (In cases where the requested care is medically inappropriate or unnecessary, for example, the care would still be denied under section 204.) There are two other factors that could cause an increase in the demand for care by Category A veterans. The fact that these veterans would now be entitled to care and the publicity surrounding the change could draw veterans to VA facilities who might otherwise have sought non-VA care. When Category A veterans were granted entitlement to inpatient care in P.L.99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, an increase of about 1.5 percent in the number of inpatient episodes of these veterans appears to have resulted from the change in law.

Also, all Category A veterans (except those with disabilities rated 50 percent disabling or more) would be entitled to all needed outpatient care under section 204, where they are currently eligible only for pre- and post-hospital care and care that would obviate the need for hospital care. This expansion of eligibility is also expected to result in only a very small increase in outpatient visits. There is very little medically necessary outpatient care that cannot be viewed as obviating the need for inpatient care. This is evidenced by the fact that in 1988 only around 1700 Category A applicants for outpatient care were turned away because they were ineligible for such care. These 1700 denials represent only 0.2 percent of applications for which outpatient care was provided.

This estimate assumes that the VA would have to expand outpatient care resources sufficiently to accommodate a 1.8 percent increase in visits by Category A veterans. This increase should cover all Category A veterans currently being denied care, as well as increases resulting from the granting of entitlement to care and the extension of eligibility to cover all needed care. The percentage increase has been adjusted downward slightly to eliminate the likelihood of overlap in the three cost factors.

The number of outpatient visits to be expected under current law was projected according to historical trends. Future average costs per outpatient visit were projected by increasing the 1988 average cost by the consumer price index for medical services.

Section 301. This section would require the VA to develop a new and improved automated system for billing and collecting fees and reimbursements owed to the VA for provision of medical care and services. Under current law, these fees and reimbursements are scored as offsetting receipts and transferred to the Treasury as miscellaneous receipts. Section 301 would establish a new distribution of these funds based on the following schedule of priorities: first, all costs of developing and operating the automated system would be paid from the collections; second, remaining amounts up to an amount equal to the CBO projection of that year's receipts shown in the fiscal year 1990 baseline would be transferred to the Treasury as offsetting receipts; finally, any residual amounts would be divided equally between the Medical Care account and the Nursing Home Revolving Fund.

If, as a result of this provision, the VA could increase the collection of fees and reimbursements by an amount equal to or greater than the cost of developing and operating the new automated system, there would be no net cost attributable to section 301. If an amount equal to the offsetting receipts reflected in the CBO baseline for Reimbursements for Medical Care is still available for transfer to the Treasury, there would be no outlay increase resulting from this provision. While there would be an increase in outlays equal to the cost of developing and operating the new system and the expenditure of any residual amounts by the Medical Care and Nursing Home Revolving Fund accounts, these amounts would, by definition, be offset by increased receipts.

There is a potential for some increase in direct spending, however. This would occur if the new system could not be put into place quickly enough to generate an increase in receipts in the first year sufficient to cover the development costs. In this instance, the first claim on the receipts would be to pay for the billing system; and the amount of receipts sent to the Treasury could be less than estimated by CBO in the baseline. Any reduction in the receipts to Treasury would be considered direct spending. It is not possible to know in advance the cost and timetable that could be expected on a contract for the new system. Therefore, the likelihood of a shortfall in Treasury receipts cannot be estimated with any degree of certainty.

Section 303(d). This section would require the VA to conduct a study of alternative methods of providing for the cost of health-care for CHAMPVA beneficiaries. The appropriation of $500,000 would be authorized for this purpose.

(by fiscal years, in millions of dollars)

	1990	1991	1992	1993	1994
Authorization Level	0.5	0	0	0	0
Outlays	0.3	0.2	0	0	0

This estimate assumes that the full amount authorized would be appropriated and would spend out according to historical spending patterns for similar activities.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENT:

The Congressional Budget Office has determined that the budgets of state and local governments would not be significantly affected by the enactment of this bill.

7. ESTIMATE COMPARISON:

In testimony before the House Committee on Veterans Affairs on April 12, 1989, the VA stated that the amendment contained in section 204 (to grant entitlement to outpatient care to all Category A veterans) would be expected to increase costs by approximately $1 billion a year. The VA's estimate is based on the total number of veterans in Category A who would become entitled to outpatient care under this bill, rather than on the number of such veterans who currently seek care from the VA.

All Category A veterans are eligible for most outpatient care from the VA under current law, and only a small number of these veterans are denied care by VA facilities. There is no evidence that a large number of Category A veterans who do not now utilize the VA for health care would do so as a result of enactment of this provision. Nevertheless, the VA estimate is based on the expectation of a large influx of veterans who have not previously used VA facilities. The CBO expects that an estimate based on current usage and denial rates will be a far better predictor of future costs than an estimate based on the population of eligibles.

8. PREVIOUS CBO ESTIMATE: None.

9. ESTIMATE PREPARED BY: K. W. Shepherd (226-2820)

10. ESTIMATE APPROVED BY:

f C. G. Nuckols
James L. Blum
Assistant Director
for Budget Analysis

Inflationary Impact Statement

The reported bill would have no inflationary impact.

Departmental Views

The following letters were received from the Department of Veterans Affairs on legislation similar to the reported bill.

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

APR 27 1989

Honorable G.V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This will respond to your request for a report on H.R. 901, 101st Congress, 1st Session, the proposed Veterans' Health-Care Programs Amendments of 1989.

We generally share the aims of this proposed legislation and favor the enactment of a number of its provisions. We would suggest a number of improvements, however, and urge that you reconsider a few of the provisions in light of our comments. Our detailed analysis follows.

NURSE SPECIAL PAY

Section 101 of the bill would provide special pay to Veterans Health Services and Research Administration (VHS&RA) registered nurses similar to that paid to VHS&RA physicians and dentists. Significant problems exist with respect to the recruitment and retention of registered nurses to work in many VA facilities, and existing incentives may not be completely adequate to solve these problems. VA's recruitment and retention difficulties are not universal, however. In some locations, VA has little difficulty recruiting nursing staff, and in a few instances, we may be one of the better paying employers. For that reason, we cannot support this broad based and expensive special pay proposal which would increase the pay of all registered nurses regardless of need for such increased pay.

The special pay provision would amend 38 U.S.C. § 4118 to authorize special pay for registered nurses in addition to physicians and dentists. It would add a new clause (C) to subsection (a)(1) providing special pay up to $7,000 per annum, amend subsection (b) to guarantee a minimum of $1,500 for primary special pay, and add new paragraphs (5) and (6) to subsection (c) providing a maximum of $5,500 for incentive special pay. In addition, with respect to incentive special pay, it would authorize maximums of $1,000 for longevity, $4,000 for certain specialties, $1,500 for service as a head nurse, and $1,500 for certain geographic areas.

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VA's staffing problems with registered nurses include both urban and rural communities in all regions of the country. We are now exercising a variety of statutory authorities to try and solve these problems, and those authorities, in many cases, are sufficient. Thus, in approximately 125 facilities, VA is using discretionary authority to establish special pay rates under section 4107(g). We are also exercising authority under section 4107(e)(10) to raise premium pay rates where necessary to meet competition from community hospitals. Finally, Public Law 100-322 provided authority for VA to expand premium pay for Saturday work, and provided for discretionary recruitment and retention bonuses, although the bonus authority has not been implemented since it was unfunded. Nonetheless, despite the enactment of these authorities, we continue to have problems in many locations.

Given the fact that there is an overall shortage of hospital registered nurses, these existing pay authorities, if all were funded, still might not enable VA to be competitive with community hospitals in all locations. In view of that, VA recently established a Nurse Pay Task Force which is developing a long range proposal for revision of the title 38 nurse pay system. The group is also developing several proposals to serve as interim measures until a pay system revision can be more fully assessed. We recommend that those proposals be allowed to develop through the normal legislative process. We strongly oppose enactment of the special pay proposal contained in H.R. 901, which we do not believe is targeted sufficiently toward solving VA's specific problems. The proposals would result in a very costly program which would in all likelihood have to be funded at the expense of other activities, that would not solve the nurse recruitment and retention problems VA has.

Allowing an offset for current special rate costs, and payment of maximum amounts of special pay authorized by the bill, we estimate that this pay proposal would result in additional costs of $17.9 million in Fiscal Year 1990, and $293.3 million over five fiscal years. Because these additional costs are unfunded, the additional pay called for by this proposal necessarily would have to come from existing salary funds.

EXPANSION OF MANDATORY PREMIUM PAY

Section 102 would amend 38 U.S.C. § 4107(e) to mandate the payment of Saturday premium pay to licensed practical nurses and nursing assistants. We believe the mandatory authority is unnecessary. We now have discretionary authority to pay LPN's (and other title 38 "hybrid" appointees) the same premium pay now authorized for registered nurses when necessary, as determined by the Secretary, for recruitment or retention.

Moreover, because we have no system-wide recruitment and retention problem with these employees, extending mandatory Saturday premium pay to all LPN's and nursing assistants, as this bill would do, is unnecessary. Furthermore, by guaranteeing all forms of premium pay for all nursing personnel, including nursing assistants and similar personnel, this proposal reduces the resources available for skilled nursing personnel for whom recruitment and retention are ongoing challenges. We estimate the cost of this section in FY 1990 to be approximately $9.6 million, and that five-year costs would be approximately $48.0 million.

EMPLOYEE OUTSIDE EMPLOYMENT LIMITATIONS

Section 103(a) would amend 38 U.S.C. § 4108 to clarify that provisions in that section prohibiting remunerated outside clinical employment do not apply to employees appointed under title 5 and paid under title 38. In fact, VA has no employees appointed under title 5 and paid under title 38. We believe this section was intended for employees in the so-called "hybrid" professions (clinical or counseling psychologists, respiratory therapists, licensed physical therapists, licensed practical or vocational nurses, pharmacists, and occupational therapists) individuals who the Secretary may appoint under 38 U.S.C. § 4104(3) pursuant to the provisions of 38 U.S.C. § 4106(g). The outside employment prohibitions imposed by section 4108 do not now apply to the persons in those "hybrid" positions. They apply only to those health-care professionals listed in section 4108, physicians, dentists, podiatrists, optometrists, nurses, physician assistants, and expanded-function dental auxiliaries. Thus, this section is unnecessary. We are willing, however, to clarify this matter through administrative means. There are no costs or savings associated with this provision.

MILITARY RETIRED PAY REDUCTIONS

Section 103(b) would expand VA's existing authority to grant exceptions to a required reduction in retired military pay for registered nurses.

Section 5532 of title 5, United States Code, now imposes upon retired officers of the uniformed services, a substantial reduction in their retired pay when appointed to civilian positions in the Federal Government. Under that section, the former officer's retired pay, following appointment, is reduced to an amount equal to $7,698.51 plus half the remainder of his retired pay. (Originally the base figure was $2,000; the statute authorizes an increase proportionate to Consumer Price

Index increases.) The statute also imposes an overall effective ceiling equivalent to Executive Level V ($75,500) of the combined retired pay and civilian pay.

Naturally, this reduction makes VA employment less attractive for retired military health care officers. We now have authority in 38 U.S.C. § 4107(i) to authorize exceptions to the statutory loss of pay for well-qualified physicians. Exercised infrequently and, we believe, prudently, the authority has nevertheless been particularly helpful in selectively recruiting highly qualified physicians in a variety of scarce categories. In our view, expansion of the authority to include retired military nurses would result in many more of these nurses seeking VA employment when they retire from the uniformed services. This expansion would be particularly helpful in recruiting and retaining nurses at facilities experiencing nursing shortages. Additionally, we recommend that the bill expand the section 4107(i) waiver authority to include not just registered nurses, but all occupations providing patient care services or services incident to direct patient care. This will improve recruitment of retiring military pharmacists, physician assistants, dieticians, therapists, and other shortage category personnel who now avoid Federal civilian employment.

The Administration urges that equivalent authority be provided for the Secretary of Defense. To provide the Secretary of Veterans Affairs authority to grant exceptions to the restrictions in section 5532 of title 5, United States Code, while failing to provide reciprocal authority to the Secretary of Defense, will further exacerbate DoD's difficulties in attracting and retaining health care professionals.

APPOINTMENT OF GRADUATES OF AFFILIATED PROGRAMS

Section 104 would amend 38 U.S.C. § 4106 to authorize VA to appoint graduates of affiliated allied health-care education programs to competitive civil service positions without regard to competitive civil service procedures. We support this provision with two modifications. Under our statutory health-care education mission, we operate clinical education programs in our facilities which annually train approximately 50,000 students in allied health-care occupations, including psychology, social work, audiology, speech therapy, dietetics and recreational therapy. Yet, the complicated and often lengthy civil service process discourages many highly-qualified allied health-care graduates of VA-affiliated clinical education programs from taking jobs with the VA. By the time these graduates complete the process for placement on a civil service register, and are certified to the VA, other health care employers have often already hired them. As a result, we lose potential employees who are already VA-trained. We are currently experiencing staff shortages in some of these positions. This proposal would enable us, without jeopardizing merit principles, to directly hire graduates of proven competence, who already are familiar with our methods, without regard to the competitive service certification process.

The first modification we would recommend is to establish standard minimum qualifications for each occupation to be used when the competitive hiring procedures are waived. This will allow VA to hire quickly, while at the same time preserving the integrity of the merit system. Such minimum qualifications could be established by VA regulation. Without such a qualifications standard, we cannot support the measure.

We suggest one other relatively minor modification in the measure. The proposed section 4106(h)(4) would authorize the Secretary to make appointments of these graduates only upon recommendation of the Chief Medical Director. It is our view that this limitation will delay the appointment process much the same as under civil service procedures. We recommend that the provision provide the Secretary with discretion to delegate appointment authority to an appropriate level.

There are no significant costs or savings associated with this proposal. However, our ability to hire these highly-qualified graduates would reduce administrative costs associated with the recruitment, orientation and training of new employees. We favor its enactment with the above changes.

RESPITE CARE PROGRAM EXTENSION

Section 201(a) would amend 38 U.S.C. § 620B to provide ongoing authority for our respite care program, authority which now expires on September 30, 1989. This extension of authority is similar to an Administration proposal transmitted to the Congress on March 20, 1989. Respite care services allow us to provide chronically ill veterans who reside at home with brief, planned periods of care in VA facilities in order to provide members of the veterans' families with some relief from the physical and emotional rigors of continuous home care. We have begun to gain experience with the respite care program which allows veterans to remain at home in the care of their loved ones, rather than requiring them to be institutionalized for protracted periods. Thus far, the program appears to be working very well as an effective mechanism for avoiding institutional care. There is no significant cost to the program. We support this proposal for ongoing authority for this successful program.

STATE HOME GRANT PROGRAM EXTENSION

Section 201(b) would authorize appropriations for the State home grant program for three years, through September 30, 1992. The State home grant program provides grant support to States to assist in the construction or acquisition of State home facilities for veterans. Over the years, these grants have created a network of 54 State veterans facilities in 36 States. These facilities make it possible to provide medical care to many more veterans than can receive care in VA facilities. It is a cost-effective program in which Federal participation is limited to no more than 65 percent of the cost of any one project. Extension of this grant program would result in estimated costs of $42 million for Fiscal Year 1990, and $126 million for the three years the program would be extended. VA supports this program, but recommends that it be extended for five years rather than three years as the bill would do.

HOUSING FOR COMPENSATED WORK THERAPY PROGRAM PARTICIPANTS

Section 202 would amend section 9 of the Veterans' Home Loan Program Improvements Act of 1987, Public Law 100-198 (38 U.S.C. § 1820 note) to authorize the Secretary to convey, at a discount, real property obtained as a result of defaults on loans made or guaranteed by the VA, to persons who contract with us to employ veterans as part of the compensated work therapy (CWT) program. Public Law 100-198 authorized the Department to convey this type of property, under certain conditions, to non-profit organizations and State and local Governments, to assist them in providing housing for homeless veterans and their families. Section 202 would extend that authority to permit similar sales to for-profit and non-profit entities which contract with us to provide CWT activities for our patients.

Pursuant to 38 U.S.C. § 618(b)(1), enacted in 1976, VA operates CWT programs in medical centers throughout the nation. It is a proven cost-effective method of rehabilitation. Under this program VA specialists develop arrangements through which VA contracts with businesses in the community to permit patients, as part of their medical rehabilitation, to perform work for the businesses. This work may take the form of either goods produced or services provided. Work is usually performed at the medical center, but may take place in another work setting. Businesses pay VA for the work performed under the contract, and those funds are deposited in the Special Therapeutics and Rehabilitation Activities Fund (STRAF), a revolving fund, authorized by 38 U.S.C. § 618(c). That fund receives no appropriations. Using funds in the STRAF, we pay patients for their work at rates consistent with the Fair Labor Standards Act. 29 U.S.C. § 201 et seq.

Although we do not have specific data, it is possible that some VA patients who participate in CWT programs are outpatients who are at risk of being homeless. Providing these patients with some form of transitional housing or residential program while they participate in the CWT program could be very beneficial to them. It would appear that the intent of section 202 is to assist contractors participating in CWT activities to obtain housing which they might then use to provide some form of transitional housing for CWT patients. We question whether entities which contract with us to provide work opportunities for CWT patients are necessarily the most appropriate organizations to provide this type of housing, or whether they would even be interested in undertaking such an endeavor. For the most part, those contractors are independent businesses which contract with our CWT programs primarily for the benefit of obtaining work from patients. We have seen no indication that these businesses are interested in providing transitional housing for CWT patients.

EXPANSION OF COMPENSATED WORK THERAPY PROGRAM

Section 203 would amend 38 U.S.C. § 618(b)(1) to broaden our authority to obtain therapeutic work for patients participating in CWT programs. Under current law, we may contract with non-Federal entities (primarily private profitmaking businesses) to obtain therapeutic work projects for CWT participants. Section 203 would expand that authority and permit similar arrangements with VA facilities and Federal entities to provide therapeutic work for patients in the program.

As discussed above, such arrangements generally involve VA entering into contracts with businesses in the community to permit patients, as part of their medical rehabilitation, to perform work for the businesses. This work may take the form of either goods produced or services provided. Opportunities for therapeutic work for patients also exist in our own facilities and other Federal entities, but existing authority now limits CWT contractual arrangements to sources "outside the Veterans Administration." 38 U.S.C. § 618(b)(1). This proposal would amend section 618 to permit arrangements, contractual or otherwise, with any appropriate source of work including VA facilities and other Federal entities.

Enactment would permit new opportunities for growth in this valuable rehabilitation program. We favor this proposal which, if enacted, would result in no new costs to the VA.

AUTOMATED FEE COLLECTION SYSTEM

Section 301 would direct that VA conduct a pilot program to test an automated system for billing and collection of fees payable to the Government in connection with several programs administered by the Veterans Health Services and Research Administration (VHS&RA). It would require that we conduct the two-year pilot program in one of our medical regions. The test program would apply to fees charged to third parties, amounts due to us under sharing agreements, amounts we may recover from insurance companies or other third party payors for care furnished to veterans, and copayments veterans agree to pay to receive VA care. The provision would also direct where we must allocate the funds collected, and the uses the funds may be put to. Under the measure, we would have to allocate twenty-five percent of the funds into the Treasury as miscellaneous receipts, twenty-five percent to the medical center which collected the funds, and fifty percent to accounts available to the Chief Medical Director. The provision would require that we use all funds retained by the Department either for benefits to enhance recruitment and retention of health care employees, or to supplement medical equipment accounts in medical centers where such funds are deficient. We cannot fully support enactment of this provision as drafted.

We are concerned with the funds allocation scheme that section 301 would impose. Under current law, the fees and charges in question are all covered over to the Treasury as miscellaneous receipts. This proposal would direct that VA retain the majority of funds collected. The purpose of the proposed change appears to be to encourage our medical centers to improve billing and collection efforts by providing that the centers and the VA would be able to retain some of the funds collected.

The funds in question are now considered proprietary receipts for budgetary purposes. Under the bill, if medical centers and the Veterans Health Services and Research Administration retain some of the funds collected, the budget process would have to take that into consideration. The total funding available to the Department would not increase as the amounts collected and retained would most likely be considered as offsets against our budget request. The same is true of the proposal's direction that retained funds be used to enhance recruitment and retention, and medical equipment accounts. Those two functions are best provided for in the normal budget process. If there is a need for funds for those purposes, centers may seek those funds in budget requests. Allowing some medical centers additional funds for those purposes because they collected monies from certain billings would only complicate the budget process, with no assurance that those centers would receive any more funds than they would have otherwise received.

Although we cannot support section 301 as drafted, we are currently pursuing greater use of automation in billings and collections and are considering other ways to improve these areas. We would support changes in this program that would permit the use of collections to offset the cost of contracting for collection services, or other similar approaches.

HEALTH CARE FOR DOD DEPENDENTS

Section 302 would authorize VA to provide health care to DoD dependents at VA facilities under VA/DoD sharing agreements. Current law prohibits the provision of such care in our facilities under VA/DoD sharing agreements. 38 U.S.C. § 5011(d)(1). We are interested in exploring avenues for sharing between VA and DoD. We are unable, at this time, however, to support the concept of VA caring for DoD beneficiaries. Such an arrangement raises numerous unresolved issues that could have a significant impact on the VA medical care system.

CHAMPVA

Section 303 would require that we compile and maintain a complete and accurate list of CHAMPVA eligibles by October 1, 1989, and establish procedures for periodic review of the cost-effectiveness and appropriateness of health care provided. It also would charge the Inspector General to report to the Committees on Veterans' Affairs regarding our compliance with these measures, and require the Secretary to report on and correct any deficiencies. Finally, it would require us to study alternative methods for providing the cost of health care to CHAMPVA beneficiaries, and report on those alternatives within a year of enactment of this statute. The provision would authorize the appropriation of $500,000 to carry out this study.

In view of the efforts underway to improve the administration of the CHAMPVA program, enactment of this proposal is unnecessary and we do not favor it. The primary actions contemplated by the bill are already in place or well underway. We now have new computer software to assist in processing applications for CHAMPVA benefits and to provide ongoing monitoring of beneficiary eligibility. The system is capable of producing a list of individuals eligible for CHAMPVA benefits, negating the need for statutory direction that such a list be developed. Moreover, in accordance with a subcommittee request made at a CHAMPVA oversight hearing held in March 1988, we now provide quarterly reports as to the costs and effectiveness of the CHAMPVA health care program.

CANTEEN SERVICE PROVISIONS

Section 304(a) would amend the Veterans Canteen Service statute to prohibit the Service from contracting out performance of any activity otherwise performed by a Federal employee compensated from non-appropriated funds.

We oppose section 304(a). It would deprive the Secretary of the flexibility necessary to operate the Service -- either with VCS employees or by utilizing contractors -- according to its needs. At individual canteens, VCS now contracts for an array of services -- ranging from vending machine to cleaning services -- which could be performed by VCS employees. Contracting decisions reflect the VCS' need for the service, its efficiency, its costs, and the availability of personnel to perform it. Generally, prohibiting VCS from contracting for services which may be performed by VCS employees could be construed to bar renewal of VCS' many existing contracts. Thus, it would eliminate any efficiencies or economies gained from existing contracts and adversely affect VCS' financial structure which reflects those economies. Applying section 304(a) only to an individual canteen, rather than to the Service as a whole, would freeze that canteen's operation, depriving the Secretary of the flexibility to adjust its operations, as to vending machine services, for example, to meet changes in the medical center or veterans' population which the canteen serves.

Section 304(b) would prohibit the head of the Canteen Service from being required to report to any VA official other than the Secretary or Deputy Secretary of Veterans Affairs. We strongly oppose section 304(b). First, this provision would require the Secretary or Deputy Secretary to exercise direct line authority over the Service, which has operations at over 170 VA medical facilities. Day-to-day administration over VCS raises operational and policy issues concerning, among other things, pricing, supply and procurement and personnel management. Title 38 does not require the Secretary and his deputy to exercise such authority over any other element of the Department. Such a role does not seem consistent with that of a Cabinet officer or his deputy. Rather, Congress in its wisdom has generally left these officials discretion as to the means through which they exercise their statutory responsibilities.

We urge against a departure from this salutary policy. It is noteworthy that Canteen Service, in its infancy, was organized within the Office of the Administrator of Veterans Affairs. The importance of having a close link between Canteen

Service and the VA medical program was highlighted in recommendations made by Booz, Allen, Hamilton which led to a 1955 reorganization. Under that realignment, VCS has successfully carried out its mission over the years, and we are aware of no subsequent management or organizational study calling into question the early judgment that the Chief Medical Director should exercise the powers and functions of the Secretary with respect to the maintenance and operation of the Canteen Service.

Moreover, the enactment of this subsection would not necessarily change the substantive operation of the Service, even though it might well have unintended adverse effects. It should be emphasized that under the longstanding provisions of the Canteen Service statute, the Secretary bears statutory responsibility for the operation of the Service. The Secretary's authority to delegate or assign specific duties relating to the Service to other VA officials does not have the effect of transferring that responsibility. And any officials making decisions about the Service under any delegated authority must ultimately answer to the Secretary for those decisions and implement policy approved by the Secretary. Section 304(b) would not enlarge the Secretary's ultimate responsibility for the Service, but only prevent the Secretary from carrying out that responsibility through delegation of authority. In our view, it would be counter-productive to limit the Secretary's discretion to provide for the management of the VCS, especially since he bears ultimate responsibility for the VCS' operation whether he delegates related duties or not.

Finally, the Secretary need not directly supervise VCS to ensure that it accomplishes its mission. All VA officials must act consistent with law, as well as their delegated duties, in carrying out policies established by the Secretary for the Service. Problems may arise but, as for any other element of the VA, can be resolved through appropriate action by the Secretary or other officials acting in his behalf. Those policy disagreements regarding the operation of the Service, which sparked the introduction of similar legislation last session, do not reflect an inadequacy in the VCS statute, but rather sincere differences over particular means adopted to implement the statute. We do not believe that legislation mandating organizational changes is warranted or will avoid the adoption of policies over which reasonable individuals may differ.

We estimate that the total cost of H.R. 901 would be approximately $70.0 million for Fiscal Year 1990, and $595.4 million over five fiscal years. Nearly half the five-year cost would be to fund the nurse special pay provision of section 101.

The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on H.R. 901 to the Congress.

Sincerely yours,

Edward J. Derwinski
Secretary

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

MAY 22 1989

Honorable G.V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This will respond to your request for a report on H.R. 1780, 101st Congress, 1st Session, a bill "[t]o amend title 38, United States Code, to revise the eligibility for outpatient medical services furnished by the Department of Veterans' Affairs." As discussed below, we do not support enactment of this bill.

With the enactment of Public Law 100-322, Congress provided for the first time that VA "shall" furnish outpatient care to certain categories of veterans. Public Law 100-322 directed that VA provide outpatient treatment, without limitation, to any veteran needing care for a service-connected condition and for any disability of any veteran who is 50% or more service-connected disabled. It also mandated that for any service-connected veterans who are 30% or 40% disabled and any other veteran whose annual income is below the maximum annual rate of pension, VA "shall" provide outpatient treatment in preparation, or to obviate the need, for hospital admission as well as to complete treatment initiated during inpatient care.

H.R. 1780 would significantly enlarge the group of veterans to whom VA "shall" provide comprehensive outpatient treatment to include all so-called "category A" veterans.

Viewed solely from an administrative perspective, there may be some merit to the concept of a common eligibility framework for all VA medical benefits, subject to differing priorities among eligible veterans. However, we do not support simply enlarging the class of veterans to whom VA "shall" provide comprehensive outpatient treatment, as proposed, particularly in light of the recent bipartisan "summit" agreement on the outlines of the FY 90 budget.

The proposed changes would certainly be far-reaching in nature. Although we are not able to offer you at this time a comprehensive analysis of its impact, we do project that enactment of such a provision would entail additional costs to VA of approximately $1 billion annually.

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The Office of Management and Budget advises that there is no objection from the standpoint of the Administration's program to the submission of this report on H.R. 1780 to the Congress.

Sincerely yours,

Edward J. Derwinski
Secretary

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

PART II—GENERAL BENEFITS

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CHAPTER 17—HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

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Subchapter II—Hospital, Nursing Home or Domiciliary Care and Medical Treatment

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§ 612. Eligibility for outpatient services

(a)(1) Except as provided in subsection (b) of this section, the Administrator shall furnish on an ambulatory or outpatient basis such medical services as the Administrator [determines are needed—

[(A) to any veteran for a service-connected disability (including a disability that was incurred or aggravated in line of duty and for which the veteran was discharged or released from the active military, naval, or air service):

[(B) for any disability of a veteran who has a service-connected disability rated at 50 percent or more; and

[(C) to any veteran for a disability for which the veteran is in receipt of compensation under section 351 of this title or for which the veteran would be entitled to compensation under that section but for a suspension pursuant to that section (but in the case of such a suspension, such medical services may be furnished only to the extent that such person's continuing eligibility for medical services is provided for in the judgment or settlement described in that section).] *determines are needed to any veteran who is eligible for hospital care under section 610(a)(1) of this title, subject to the same limitations as apply under subparagraphs (A) through (I) of that section with respect to eligibility for hospital care under that section.*

[(2) The Administrator shall furnish on an ambulatory or outpatient basis medical services for a purpose described in paragraph (5) of this subsection—

[(A) to any veteran who has a service-connected disability rated at 30 percent or 40 percent; and

[(B) to any veteran who is eligible for hospital care under section 610(a) of this title and whose annual income (as determined under section 503 of this title) does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 521(d) of this title.

[(3) The Administrator may furnish on an ambulatory or outpatient basis medical services which the Administrator determines are needed—

[(A) to any veteran who is a former prisoner of war;

[(B) to any veteran of the Mexican border period or of World War I; and

[(C) to any veteran who is in receipt of increased pension or additional compensation or allowances based on the need of regular aid and attendance or by reason of being permanently housebound (or who, but for the receipt of retired pay, would be in receipt of such pension, compensation, or allowance).

[(4)] *(2)* Subject to subsection (f) of this section, the Administrator may furnish on an ambulatory or outpatient basis medical services for a purpose described in paragraph [(5)] *(3)* of this subsection to any veteran who is eligible for hospital care under section 610 of this title and who is not otherwise eligible for such services under this subsection.

[(5)] *(3)*(A) Medical services for a purpose described in this paragraph are medical services reasonably necessary in preparation for hospital admission or to obviate the need of hospital admission. In the case of a veteran described in paragraph [(4)] *(2)* of this subsection, services to obviate the need of hospital admission may be furnished only to the extent that facilities are available.

(B) In the case of a veteran who has been furnished hospital care, nursing home care, or domiciliary care, medical services for a purpose described in this paragraph include medical services reasonably necessary to complete treatment incident to such care. Such medical services may not be provided for a period in excess of 12 months after discharge from such care. However, the Administrator may authorize a longer period in any case if the Administrator finds that a longer period is required by reason of the disability being treated.

[(6)] *(4)* In addition to furnishing medical services under this subsection through Veterans' Administration facilities, the Administrator may furnish such services in accordance with section 603 of this title.

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§ 618. Therapeutic and rehabilitative activities

(a) * * *

(b)(1) In furnishing rehabilitative services under this chapter, the Administrator, upon the recommendation of the Chief Medical Director, may enter into [contractual arrangements with private industry or other sources outside the Veterans' Administration] *a contract or other arrangement with any appropriate source (whether or not an element of the Department of Veterans Affairs or of any other Federal entity)* to provide for therapeutic work for patients and members in Veterans' Administration health care facilities.

* * * * * * *

(c)(1) There is hereby established in the Treasury of the United States a revolving fund known as the Veterans' Administration Special Therapeutic and Rehabilitation Activities Fund (hereinafter in this section referred to as the "fund") for the purpose of [carrying out the provisions of] *furnishing rehabilitative services authorized in* subsection (b) of this section *and for the purpose of carrying out section 203 of the Veterans' Health-Care Programs Amendments of 1989*. Such amounts of the fund as the Administrator may determine to be necessary to establish and maintain operating accounts for the various rehabilitative services activities may be deposited in checking accounts in other depositaries selected or established by the Administrator.

(2) All funds received by the Veterans' Administration under contractual arrangements made under subsection (b) of this section, or by nonprofit entities described in paragraph (2) of such subsection, *and all funds received by the Department as rent under section 203 of the Veterans' Health-Care Programs Amendments of 1989* shall be deposited in or credited to the fund, and the Administrator shall distribute out of the fund moneys to participants at rates not less than the wage rates specified in the Fair Labor Standards Act (29 U.S.C. 201 et seq.) and regulations prescribed thereunder for work of similar character. *The Secretary may also distribute out of the fund such amounts as may be necessary for the acquisition, management, maintenance, and disposition of real property for the purpose of carrying out such section 203.*

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§ 620B. Respite care

(a) * *

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[(c) The authority provided by this section terminates on September 30, 1989.]

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PART IV—GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 73—DEPARTMENT OF MEDICINE AND SURGERY

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Subchapter I—Organization; General

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§ 4106. Period of appointments; promotions

(a) * * *

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(h)(1) The Secretary may appoint qualified individuals in the competitive civil service without regard to the provisions of subchapter I

of chapter 33 of title 5 (other than sections 3303 and 3328 of such title).

(2) For purposes of this subsection, an individual shall be considered to be a qualified individual if the individual—

(A) has a recognized degree or certificate from an accredited institution in a health-care profession or occupation; and

(B) is appointed to and has successfully completed a clinical education program affiliated with the Department.

(3) In using the authority provided by this subsection, the Secretary shall apply the principles of preference for the hiring of veterans and other persons established in subchapter I of chapter 33 of title 5.

§ 4107. Grades and pay scales

(a) * * *

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(e)(1) * * *

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(11) For purposes of this subsection, an employee of the Veterans Health Services and Research Administration who is a licensed practical or vocational nurse or a nurse assistant shall be treated in the same manner as a registered nurse.

* * * * * * *

(i) The Administrator may authorize an exception to the restrictions in subsections (a), (b), and (c) of section 5532 of title 5 if necessary to meet special or emergency employment needs which result from a severe shortage of well-qualified candidates in physician positions, *and registered nurse positions,* which otherwise cannot be readily met. *The authority of the Secretary under the preceding sentence with respect to registered-nurse positions expires on September 30, 1992.*

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(k) In the case of specific physician positions in a specialty which the Secretary has determined to be a specialty in which it is extremely difficult to recruit and retain physicians, the Secretary may waive the applicability to any such position of—

(1) the limitations in subsection (d)(3) of this section and section 5308 of title 5; and

(2) paragraphs (2) and (3) of subsection (g) of this section.

§ 4108. Personnel administration

(a) * * *

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(e) Any provision of this title limiting employment outside of the Department by an employee of the Department shall not apply to an employee described in section 4104(3) of this title.

(f)(1) The Secretary may carry out a leave-sharing program for employees subject to this section who face medical emergencies (either for themselves or family members). Any such program shall be consistent with the leave-sharing programs authorized in subchapter III (beginning with section 6331) and subchapter IV (beginning with

section 6361) of chapter 63 of title 5 for employees appointed under title 5.

(2) The authority to carry out such a program shall terminate on September 30, 1994.

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CHAPTER 75—VETERANS' CANTEEN SERVICE

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§ 4203. Operation of Service

(a) * * *

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(c) A contract or other agreement may not be made by or on behalf of the Service for performance by an individual not directly employed by the United States of any activity otherwise performed by an individual employed by the United States who is compensated with nonappropriated funds.

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§ 4208. Service to be independent unit

[It is the purpose of this chapter that, under] *Under the* control and supervision of the Administrator, the Service shall function as an independent unit in the Veterans' Administration and shall have exclusive control over all its activities including sales, procurement and supply, finance, including disbursements, and personnel management, except as otherwise provided in this chapter. *The head of the Service may not be required to report to or be supervised by any official of the Department other than the Secretary and Deputy Secretary.*

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PART VI—ACQUISITION AND DISPOSITION OF PROPERTY

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CHAPTER 81—ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY

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Subchapter 1—Acquisition and Operation of Medical Facilities

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§ 5011. Sharing of Veterans' Administration and Department of Defense health-care resources

(a) * * *

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(g) For the purposes of this section:

(1) * * *

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(5) The term "primary beneficiary" (A) with respect to the Veterans' Administration means a person who is eligible under this title (other than under section 611(b) or 613 or subsection (d) of this section) or any other provision of law for care or services in Veterans' Administration medical facilities, and (B) with respect to the Department of Defense, means a member or former member of the Armed Forces who is eligible for care under section 1074 of title 10 *or a dependent (as defined in section 1072(2) of such title) who is eligible for care under section 1076 of such title.*

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§ 5016. Nursing home resolving fund

(a)(1) Amounts [realized from a transfer pursuant to] *referred to in section 629(g)(3) and* section 5022(a)(2)(C) of this title shall be administered as a revolving fund and shall be available without fiscal year limitation.

(2) The revolving fund shall be deposited in a checking account with the Treasurer of the United States.

(b)(1) The expenditure of funds from the revolving fund may be made only for the construction, alteration, and acquisition (including site acquisition) of nursing home facilities and [may be made only as] *shall be made subject to such limitations as are* provided for in appropriation Acts.

(2) For the purpose of section 5004(a)(2) of this title, a bill, resolution, or amendment which provides that funds in the revolving fund may be expended for a project involving a total expenditure of more than $2,000,000 for the construction, alteration, or acquisition (including site acquisition) of a nursing home facility shall be considered to be a bill, resolution, or amendment making an appropriation which may be expended for a major medical facility project.

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Subchapter II—Procurement and Supply

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§ 5023. Procurement of prosthetic appliances

(a) The Administrator may procure prosthetic appliances and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Administrator may determine to be proper, without regard to any other provision of law.

(b) The Secretary shall develop standards, based on the number of eligible veterans seeking prosthetic and sensory aids services from the Department at a medical facility, for the staffing of medical facilities of the Department to provide for—

(1) the assignment of sufficient numbers of qualified disabled prosthetic representatives at each medical center; and

(2) the operation of prosthetic and sensory aids services at each medical facility with an active prosthetic patient load.

(c) The Secretary shall carry out a program for the training and continuing education of prosthetic representatives, orthotists, prosthetists, and other health care professionals involved in providing and prescribing prosthetic services.

(d) Not later than February 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the funding and operation of the prosthetics program of the Department. Each such report shall include the following:

(1) A description and analysis, by medical center, of the duration of time between the date on which each order for prosthetic services was placed by an eligible veteran during the period of time covered by the report and the date on which such service was delivered. Such analysis shall include a statement of the following:

(A) A list of facilities at which the duration of time exceeded 5 days in any case.

(B) The number of orders, shown by facility, for which the duration of time was more than five days and the actual amount of time elapsed in filling each such order.

(C) The total dollar amount of orders for which the duration of time was more than five days.

(D) The reasons for the duration of time for delivering services in accordance with such orders being in excess of five days.

(2) A statement of the number of medical facilities at which qualified disabled prosthetic representatives are employed and the number of medical centers operating Prosthetic and Sensory Aids Services.

(3) A description of the training provided to prosthetic representatives, orthotists, prosthetists, and other health care professionals involved in providing and prescribing prosthetic services.

(4) A description of the actions taken during the period covered by the report to expedite the purchases of prosthetic appliances.

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Subchapter III—State Home Facilities for Furnishing Domiciliary, Nursing Home, and Hospital Care

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§ 5033. Authorization of appropriations

(a) There are hereby authorized to be appropriated such sums as are necessary to carry out this subchapter through September 30, [1989] *1992*. Sums appropriated pursuant to this section shall be used for making grants to States which have submitted, and have had approved by the Administrator, applications for carrying out the purposes and meeting the requirements of this subchapter.

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SECTION 19011 OF THE VETERANS' HEALTH CARE AMENDMENTS OF 1986

Subtitle A—Health Care

SEC. 19011. ELIGIBILITY FOR HEALTH CARE OF VETERANS WITH NON-SERVICE-CONNECTED DISABILITIES.

(a) * * *

(e) REPORTS ON FURNISHING OF HEALTH CARE AND IMPLEMENTATION OF CHANGES IN ELIGIBILITY.—(1) The Administrator of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report for each of fiscal years 1986, 1987, [and 1988], *1988, 1989, 1990, and 1991* concerning the implementation of the amendments made by this section.

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SECTION 115 OF THE VETERANS' BENEFITS AND SERVICES ACT OF 1988

SEC. 115. PILOT PROGRAM OF COMMUNITY-BASED RESIDENTIAL CARE FOR HOMELESS CHRONICALLY MENTALLY ILL AND OTHER VETERANS.

(a) * * *

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(d) DURATION OF PROGRAM.—The authority for the pilot program authorized by this section expires on September 30, [1989] *1992*.

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SECTION 110 OF THE VETERANS' HEALTH CARE ACT OF 1984

POST-TRAUMATIC-STRESS DISORDER

SEC. 110. (a) * * *

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(e)(1) * * *

(2) Not later than February 1, 1986, and February 1 of each of the [three] *six* following years, the Administrator shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection before the submission of such report.

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SECTION 9 OF THE VETERANS' HOME LOAN PROGRAM AND IMPROVEMENTS AND PROPERTY REHABILITATION ACT OF 1987

SEC. 9. PROPERTY MANAGEMENT.

(a) HOMELESS PROGRAM.—(1) * * *

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(3) The Administrator may enter into an agreement under paragraph (1) only if—

(A) the Administrator determines that such an action will not adversely affect the Veterans' Administration's ability—

(i) to fulfill its statutory missions with respect to the Veterans' Administration loan guaranty program and the short- and long-term solvency of the Loan Guaranty Revolving Fund under such chapter 37; or

(ii) to carry out other functions and administer other programs authorized by law;

(B) the entity to which the property is sold agrees to (i) utilize the property [solely as a shelter] *as a shelter or as transitional housing* primarily for homeless veterans and their families, (ii) comply with all zoning laws relating to the property, (iii) make no use of the property that is not compatible with the area where the property is located, and (iv) take such other actions as the Administrator determines are necessary or appropriate in the best interests of homeless veterans and the Federal Government; and

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(c) VETERANS PARTICIPATING IN COMPENSATED WORK THERAPY PROGAM.—(1) To assist veterans who are participants in a compensated work therapy program authorized under section 618 of title 38, United States Code, the Secretary of Veterans Affairs may convey to persons described in paragraph (2) real property and improvements described in subsection (a)(2) for an amount not less than 75 percent of the fair market value of such real property and improvements.

(2) The Secretary may convey such property to persons who enter into an agreement with the Secretary to employ veterans who are participants in a compensated work therapy program authorized under such section 618.

(3) The Secretary may include appropriate enforcement provisions in any agreement described in paragraph (2), including provision for reasonable liquidated damages.

[(c)] *(d)* TERMINATION.—The authority provided in [subsections (a) and (b)] *this section* shall terminate on October 1, 1990.

[(d)] *(e)* REPORT.—The Administrator of Veterans' Affairs shall, by March 1, 1990, transmit to the Congress a report of the activities carried out, through December 31, 1989, under this section.

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